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The care perspective in medical ethics education : perceptions of physician-educators.

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THE CARE PERSPECTIVE IN MEDICAL ETHICS EDUCATION: PERCEPTIONS OF PHYSICIAN-EDUCATORS

A Dissertation Presented

by

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DEDICATION

To my Family: my husband, Steve; my parents, Connie and Raymond Small; my sons and daughters and their spouses; Steve and Niena, Michael and Karen, Tom, Lyn and Jim, Jerry and Darlene, Jennie and Kevin, in recognition of their love and devotion as I pursued one of my dreams. And to my eight grandchildren: Michelle, Jessica, Vanessa, Stephen, Danny, John, Janelle, and Connie, with whom I share enthusiasm and joy in living, loving, and learning every day.

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ABSTRACT

THE CARE PERSPECTIVE IN MEDICAL ETHICS EDUCATION:
PERCEPTIONS OF PHYSICIAN-EDUCATORS

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The purpose of this study is to describe the perceptions of medical educators regarding the care perspective and to examine implications for medical ethics education.

After many years of being omitted from the theory of medical ethics, the care perspective is beginning to emerge in theoretical discussion. Work to date does not tell us whether or how physician-educators view or use the care perspective in medical practice and/or in medical ethics education. Yet it is physician-educators who influence the content and focus of medical ethics education.

In this exploratory, qualitative study, in-depth focused interviews were conducted with ten physician-educators who teach medical ethics at one academic medical center. A systematic multiple level analysis of participants' responses led to the identification of themes, patterns and interrelationships of data which were supported by case stories. The study yielded thick, rich narrative descriptions and the original commentary was

retained to preserve the language, imagery and reflections of the physician-educator's experiences, styles and approaches.

The findings suggest that some physician-educators use several different approaches to the medical ethical decision making process including the care perspective. They believe the care perspective: is implicit in medical practice; is essential and should be made explicit in the medical ethical decision making process, where as an ethical approach, it may avert certain ethical dilemmas and even lawsuits; must be made explicit in medical ethics education, both in the classroom and clinical setting; and instruction should be extended over the entire period of a medical student's education.

The purpose of this study is to learn how the care perspective is regarded, understood and used, if at all, by physicians who are directly involved in medical ethics education. While the findings contribute to a larger understanding of the place of the care perspective in medical practice and in medical ethics education, they also raise new questions that suggest further study.

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C H A P T E R 1

THE CARE PERSPECTIVE IN MEDICAL ETHICS EDUCATION: PERCEPTIONS OF PHYSICIAN-EDUCATORS

Introduction

This study is concerned with the care perspective in medical ethics education, a new and somewhat controversial approach to ethical decision making. To date, the discussion of the care perspective in medical ethics education has been from the viewpoint of medical ethicists, that is, theoreticians. My study seeks to explore the views on the care perspective in medical ethics education of those who teach medical ethics to medical students, that is, physician-educators. As necessary background to my research, in Chapter One, I briefly describe the links between medical practice, medical educators, medical ethics and medical ethics education. I also describe the chain of events that led to the introduction of the care perspective as one approach to the medical ethical decision making process in medical ethics education. These events include changes in medical practice, in medical ethics, in medical education and, finally, changes in the theoretical approach that have led to interest in the care perspective in medical ethics and medical ethics education.

A Chain of Events

Changes in Medical Practice

Over time, social and technological changes have led to changes in medical practice and the erosion of a caring ethic. To many patients the image of a doctor is akin to a Norman Rockwell painting of the kind, gentle, fatherly man who makes house calls, patiently holds hands and seems intuitively attuned to his patients' needs. Doctors, too, identify with this image as a role model. But the world of the modern doctor is far removed from this idealized picture. Societal and technological factors have created complicated and impersonal health care settings and experiences for most patients and physicians.

What Rockwell did capture was a sense of caring and trust between physician and patient which many people considered and still consider the cornerstone of both a good relationship and good medical care. The medical care he was depicting, representing the medical care in the 1940s, was often conducted in the private realm of the home. Patients were born there, had children and illnesses there and died there. People survived serious ailments, infections and disease with little or no assistance from medical technology, or died. Physicians could not offer effective treatments for most diseases but they did try to alleviate suffering and pain. Physicians treated illnesses of entire families and extended families and very often had long-term inter-generational relationships with their

patients. By the 1980s, however, the Rockwell image no longer pertained. Few patients were seen by family doctors and few, even within the same family, were seen by the same doctor. The family physician providing home care had faded away and the close and inter-generational relationships were lost.

One explanation for the changes in medical practice is found in the scientific and technological revolution that has and is occurring at academic medical centers ("AMCs"). AMCs with their research facilities, their hospitals and their medical schools are the primary location for change in medical practice. AMCs specialize in state-of-the-art medical research, medical practice and medical training. Following World War II, medical scientists at AMCs unleashed a whole host of new drugs and experimental treatments, ranging from penicillin to in-utero gene therapy, that forever changed medical practice. Technological advances in medical science could now extend life for decades through surgery, drugs or machinery. Machines could successfully replicate the vital life-defining functions of major organs like the heart, lungs and kidneys. Patients could even be fed and hydrated artificially. The list of possible interventions is endless. There seems to be no foreseeable limit as to what medical science and technology can offer medical practice.

Changes in Medical Ethics

Medical technological advances such as those mentioned above were initially viewed as scientific breakthroughs that solved baffling medical problems. As time went on physicians, as well as other people, began to realize these medical advances were also creating baffling ethical dilemmas - for which physicians were unprepared.

Medicine had been concerned with ethical issues and practices from the time of Hippocrates (400 B.C.) and Maimonides (1200 A.D.). Ethics is very simply defined by Webster's Dictionary (1987) as "the discipline dealing with what is good and bad and with moral duty and obligation", a "theory or system of moral values" and "the principles of conduct governing an individual or a group". Ethics is also defined as the study and philosophy of human conduct with emphasis on the determination of right and wrong (Funk & Wagnalls, 1956). As medicine's ability to intervene with and redefine life and death increased, physicians, patients and others became concerned with such accompanying issues as: 1) when is it appropriate to use available technologies (for example, to create life, to sustain life, and/or to preclude death); 2) who are the decision makers; and 3) how should limited resources be used. The media, the public, ethicists and physicians called for ethical responses to these new and more complicated issues raised by modern medicine. The media exposed abuses and potential abuses in medical research. The public reacted to such cases as the

Karen Anne Quinlan case and the story of Baby M and expressed concerns about ethical issues in medicine that impacted personal medical care or the medical care of loved ones.

In the 1970s a small group of philosopher-ethicists (mainly Beauchamp & Childress) were the first to formally respond to the growing number and complexity of ethical issues raised in medical practice. They crafted four formal ethical rules for use in medical research settings: autonomy, beneficence, non-maleficence and justice. The National Commission for the Protection of Human Subjects codified these principles in the mid 1970s. The principles were later called the justice perspective and over time the justice perspective became synonymous with medical ethics. The justice perspective was so successful in the sphere of protecting human research subjects that it was adopted for all medical practice.

Modern medical ethics in a broad sense is a discipline that examines 'the rightness', 'the wrongness', the 'goodness' or the 'utility' of medical decisions (Beauchamp & Childress, 1982). The term "medical ethicist" describes people who study medical ethics. Medical ethicists draw from two groups both of whom have approached medical ethics from the justice perspective. The earliest and largest group have been the philosopher-ethicists. They were the most influential largely because they were the first theoreticians. This group was followed about ten years

later by a small group of physician-ethicists who combine the theoretical aspects of modern medical ethics (i.e., the justice perspective) with the clinical aspects of medicine.

Changes in Medical Ethics Education

In the same fifty-year time period from World War II to the present, when there were major changes in medical practice and in the development of medical ethics, medical education remained essentially the same. Then in the late 1980s, medical ethics was introduced as a subject of study in medical education. Some background on medical education will explain the interrelationships between medical education, medical practice and medical ethics and the changes that were and are occurring in medical ethics education.

Medical schools, designed exclusively for the education of physicians, are jointly accredited by the Association of American Medical Colleges (AAMC) and the American Medical Association through the Liaison Committee on Medical Education (LCME). Since 1910, medical education has been standardized across the United States and Canada: all medical schools have a four-year, common core curriculum that includes study in both the basic and clinical sciences. In addition, all states require one year of residency for licensure. The curriculum has centered around scientific facts, organ systems and diseases. Subjects that were not "science" were not

taught. "Medical training" is a major part of medical education. In the medical training programs, physician-educators train all medical students in areas such as surgery, pediatrics and Ob-Gyn. Medical training is inseparable from medical practice, that is, the treatment of patients. Physician-educators at AMCs provide medical care for their patients at the same time that they are providing instruction to medical students. Medical students and residents work with senior physicians to learn scientific, technical, practical and interpersonal skills. Patients and their medical problems and treatments serve as the instructional material. Medical students and residents have to pass three levels of national exams, U.S. Medical Licensing Exams (USMLE), to practice medicine as physicians. Most new physicians then train as specialists with focused expertise in state-of-the-art technology to keep pace with scientific changes. In order to specialize, physicians must receive an additional two to seven years of intense post-graduate training in residency programs. There is little time anywhere in the current curriculum to given to non-scientific matters.

Medical schools and medical educators did not include any formal training in ethics before the 1980s; nor were formal courses in ethics required by the LCME or by the state licensing boards. Although formal ethics courses are quite recent, the Oaths of Hippocrates and Maimonides, as well as medical education, had for centuries emphasized

that medicine was essentially a moral enterprise. They could not anticipate and, therefore, did not begin to address the ethical issues that arose from advances in science and technology and from societal changes. The oaths did not give sufficient guidance to either modern medical practice or contemporary medical ethics education.

It is unclear from the literature why physicians did not receive formal training in ethics other than that it was not a "science." By the 1980s some physicians recognized a need to teach ethics as part of a medical school curriculum and some medical schools began to require their students to study medical ethics. By 1990, the LCME required each medical school to include medical ethics courses in the curriculum for accreditation but did not dictate what had to be taught in them or the proportion of time spent on medical ethics in the total curriculum.

Presently medical ethics education has two forms: one that is formally called medical ethics education and the other which occurs as part of "medical training". The first typically consists of a few hours of formal instruction in the total four year course of study. For example, a twelve-hour course (that is, 720 minutes total) called medical ethics may be divided into three hours of classroom lectures and/or case studies followed by nine hours of small group discussion. Faculty who teach medical ethics instruct medical students to examine the ethical issues involved as well as to analyze the medical facts and

diagnose a patient's illness when making a decision about medical treatment. I call this medical ethical decision making process the "MedMap" in this study.

Medical ethics courses are sometimes taught jointly by a physician and a medical ethicist (that is, either a philosopher-ethicist with a background in philosophy or a physician-ethicist with a background in clinical medicine who has taken advanced courses in medical ethics). For the most part, though, the faculty in medical ethics are physician-educators who have expressed an interest in medical ethics. Physician-educators are rarely medical ethicists, that is, holding degrees in ethics or philosophy. Only a few have had any formal training in medical ethics and most have very limited experience in training medical students in the realm of ethics.

The second form of instruction is provided by the same physician-educators who, in addition to classroom instruction, also teach medical ethics directly in their medical training programs. Thus physician-educators who teach medical ethics usually provide instruction in the MedMap through a combination of textbook reading, case studies and medical training.

Changes in Theoretical Approach Have Led Some Medical Ethicists to the Care Perspective

The first medical ethics textbooks, written by Beauchamp and Childress in the 1970s equated medical ethics with the four principles of the justice perspective. The

four principles were first defined and then applied to various case studies. Over the years, faculty at AMCs have used these textbooks and others based on them for teaching medical ethics. As a result, and quite ironically according to some critics, caring and certain other core values closely associated with the medical profession for centuries were pushed deep into the background in medical practice, and omitted from the theory in medical ethics and medical education in the post-war years.

Recently, some physicians and ethicists are re-discovering the importance of caring relationships. This group believes that the justice perspective does not fully capture or fully apply to the complex ethical decisions required in modern medical practice because the concept of care has not been included. They have proposed a different approach or theory upon which to base medical ethical decisions which they call the care perspective.

The Care Perspective in Medical Ethics

The care perspective is a curious combination of an old and a new construct in medical ethics. It is complex, multi-layered and still developing. Because it is the focus of my study, I will define it briefly here and elaborate on it more fully in Chapter Two.

Feminist and nurse ethicists define the care perspective as the quality of binding to another human being through relationships and emotional attachments

(Gilligan, 1982; Noddings, 1984). For them, this type of relationship gives meaning to human life. In medical ethics, the care perspective is most often described as an orientation or approach to ethical decision making (Levine, 1990; Carse, 1991). For the purpose of this study, the care perspective will mean the description of a theoretical ethical construct which places the quality of human relationships at the center of ethical decision making.

Both adherents and critics, frequently place the care perspective in juxtaposition to the justice perspective (described earlier). For example, Robert J. Levine, a physician-ethicist at Yale Medical School and a proponent of the care perspective, defines it thus:

> [there are] two major styles of reasoning about ethical problems. Justice based reasoning entails solving problems according to abstract, rationally derived rules. Care based reasoning, by contrast, focuses on responding to the needs of particular persons even if this means some rules must be bent or broken. Justice based reasoners favor detachment in ethical reasoning - the rules apply no matter who is involved. Care based reasoners emphasize the importance of emotional attachment between persons (i.e., the importance of relationships) (1990, p. 24).

Proponents of the care perspective believe that not only should the medical school curriculum include medical ethics, but also that medical ethics theory and practice should include the care perspective as an approach to the MedMap. They believe medicine's goal is to focus on patient care. They believe that in addition to being technically proficient, medical students and residents must be taught ethical approaches in order to give better

patient care. Part of this ethical training would include instruction on how to develop an awareness and respect for patients and their relationships. The proponents worry that if the care perspective remains as it has in the past, implicit, unidentified, unnamed and unacknowledged then it will continue to be omitted in medical ethics theory, it will not be included in medical ethics education, it will not be used in the MedMap, and both patient care and medical education will be the poorer for its absence (Levine, 1990; Carse, 1991). Their argument is simple: the care perspective is an ethical approach that has always existed at least implicitly in medical practice. It is time to 1) rediscover it as a formal construct, 2) find its place in modern medicine, 3) include it in Medical ethics training, use it, teach it, and ultimately enrich the MedMap.

The care perspective has not yet been universally accepted in medical ethics theory. There are some scholars who completely disagree with the proponents of the care perspective in medical ethics education and some who do not deign to express their opposition in writing but instead devalue it by disregarding it (See chapter 2).

To summarize, the care perspective appears to be a relatively unexamined area, in which interest is growing, in both medical ethics and medical ethics education. But the discussion to date, has been by medical ethicists - both physician-ethicists and philosopher-ethicists, and it

has, to the best of my knowledge, been largely confined to theoretical discussions. There have been few, if any, articles written by physician-educators and little, if any, research on the views of the physician-educators on the care perspective.

Problem Statement and Purpose of the Study

After many years of being omitted from the theory of medical ethics, the care perspective is beginning to emerge in theoretical discussions in medical ethics. Work to date on the care perspective, does not tell us how physician-educators view or use it in medical practice and/or in medical ethics education. Yet it is physician-educators who have the most profound impact on the content and focus of clinical education and medical ethics education. It is they who are molding future generations of physicians and in doing so are setting the climate for medical practice. The lack of knowledge about what practicing physician-educators think about the care perspective in Medical ethics and medical ethics education is the problem to be explored in this study.

The purpose of this study, then, is to learn how the care perspective is regarded, understood and used, if at all, by the physicians who are directly involved in medical ethics education. The study will contribute to a larger understanding of the place of the care perspective in medical practice and medical ethics theory and education.

Definition of Terms

* Academic Medical Center (AMC) means the educational complex which includes: a medical school of a major university, a university hospital, and graduate schools in other health disciplines, such as nursing, health sciences, and biomedical sciences. Faculty at an AMC instruct medical students and residents through direct patient care at the teaching hospital(s). There are 123 academic medical centers in the United States.

* Care Perspective for the purposes of this study will be taken to mean the description of a theoretical ethical construct which places the quality of human relationships at the center of ethical decision making.

* Encounter means a medical appointment or "visit with the doctor." In an encounter both physician (health care provider) and patient (consumer) are present.

* Ethics, simply stated, means the study and philosophy of human conduct with emphasis on the determination of right and wrong (Funk & Wagnalls, 1956).

* Family means any one of the following, alone or in conjunction with others: persons sharing a biological relationship, marital relationship, intimate but non-marital relationship, one or more persons who are in a very close relationship such as family of origin, family of choice, or other groupings that represent the modern family.

* Justice Perspective refers to one approach to the medical ethical decision making process. It includes four fundamental ethical principles that apply to doctor/patient relationships: autonomy, non-maleficence, beneficence and justice.

* Medical Ethical Decision Making Process ("MedMap") means that both medical and ethical information are incorporated into the decision about medical treatment.

* Medical Ethics is a discipline that in a broad sense examines "the rightness," "the wrongness," "the goodness" and/or the "utility" of medical decisions (Beauchamp & Childress, 1982).

* Medical ethicists refers to two groups who are essentially scholars and theoreticians: the earliest (1970 to present) are philosopher-ethicists with a background in philosophy and later (mid-1980s to present) physician-ethicists with a background in clinical medicine who attempt to bridge theory and practice and make them compatible. A medical ethics faculty may include a medical ethicist or may consist entirely of physicians with little or no formal training in medical ethics.

* Medical training. In medical training, physician-educators work directly and simultaneously with both patients and students: treating the patients while they are instructing the students.

* Resident means a physician in training. All states in the U.S. require a minimum of one year of residency

training in order to receive licensure to practice medicine. For specialty boards, a person holding a medical degree (M.D.) is required to complete from two to seven years of additional training before being licensed to practice the specialty with no supervision.

The study will also have implications for the teaching of medical ethics as it may lead others to reexamine in greater depth the content of medical ethics courses and clinical medical training, the issues addressed, the forms of discourse used, the skills and sensitivities developed, and the values and ideas included in the MedMap (Carse, 1991). In addition, the findings from this study may suggest new research that may yield insights into the nature and dynamics of the care perspective as an ethical construct in medicine.

Limitation of the Study

This study does not attempt to resolve the theoretical debate as to whether the care perspective is or is not a proper ethics theory or a principle of ethics. It is also beyond the scope of this paper to examine whether the care perspective should be the only theory taught in medical ethics or whether it should complement traditional ethical theories.

This study is limited to describing how the care perspective is presented in the literature and thought of in 1994 by a group of physician-educators at one academic medical center. Although the study includes descriptions of how the care perspective is used in medical practice and education by physician/educators it includes no independent evaluation of its use.

C H A P T E R 2

LITERATURE REVIEW

Introduction

This review describes the gradual development of the literature on the care perspective and the evolving connections between the care perspective in medical practice, medical ethics and medical education.

The care perspective first emerged in feminist literature on moral development (Gilligan, 1982) and in literature about nursing ethics in the 1980s (Noddings, 1984). Despite many articles on the care perspective found in these scholarly fields, writers in medical ethics appear to have been unfamiliar with the groundwork established in these academic communities. From among dozens of writers, only the works of Gilligan (1982, 1988) are referenced. Thus there are major theoretical gaps in the medical ethics literature.

Most of the relevant articles in medical ethics could be categorized as precursors to the care perspective in medical ethics. These are works of a few medical ethicists who became dissatisfied with the justice perspective. Although they do not mention the care perspective by name, works by Kass (1990), Toulmin (1981), and Churchill (1989) paved the way for its introduction, and are referenced by the proponents of the care perspective who came later. It

should be noted that the care perspective is almost always discussed in contrast to the justice perspective.

The actual articulation of the care perspective in medical ethics literature began in the 1990s. To date, the few articles are exploratory and tentative in nature, with little uniformity in vocabulary or unanimity in direction or emphasis. For example, in the six or so relevant articles (Kass, Toulmin, Churchill, Levine, Carse, and Howe [1992]), only a few (Levine, Carse, Howe) discuss the care perspective by that name. Others label it the ethic of caring or the care orientation or care-based reasoning. Very few articles in the literature address the specific issue of the care perspective as an ethical approach to the MedMap in medical ethics education. For these reasons there are somewhat confusing gaps, unexplored areas, contradictions and hairline distinctions. Nonetheless, the literature suggests that there is a growing interest in the care perspective in medical ethics education and its proponents call for additional scholarly research and debate (Levine, Carse).

The first part of this literature review summarizes the stages that led to the care perspective in medical ethics and offers an explanation of why it has been overlooked or omitted until recently in medical ethics theory. The second part defines the care perspective. The third reviews the care perspective's connections with medical practice through three phases: its implicit phase,

omitted phase and the current phase where it is emerging in medical ethics literature. The fourth summarizes proponents and opponents views of the care perspective in medical ethics education. The fifth part briefly looks at concepts of care as emerging in the reform literature in medical education.

Stages That Led to the Care Perspective in the Medical Setting

Several scholars have described the origins and development of medical ethics and the principles of the justice perspective, the perceived problems of the justice perspective and why some physicians and ethicists have recently introduced the care perspective.

Origins of Modern Medical Ethics

In "Metamorphosis of Medical Ethics," Pellegrino (1993), a physician-ethicist at the Kennedy Center of Bioethics at Georgetown University Medical Center, briefly reviews the rapid, profound and on-going changes in medical ethics from the 1970s to the present. Levine, a physician-ethicist at Yale University Medical School, in "Medical Ethics and Personal Doctors: Conflicts Between What We Teach and What We Want" (1990) also reviews the changes and notes the impact they have on medical ethics education. It becomes evident from these articles and from the early scholarship itself that medical ethics theory was

influenced more by philosopher-ethicists than by physician-ethicists during its emergent stages.

According to Pellegrino and Levine, medical ethics as we know it began in the 1970s in response to such things as: technical advances that radically changed medical practice; cultural changes that pitted the individual against the establishment and media scrutiny that revealed abuses in medical research (Levine, 1990; Pellegrino, 1993). More specifically, major scientific and technological advances in medical research and practice led to both specialization and the erosion of a caring ethic (Carper, 1986; Levine, 1990; Pellegrino, 1993). In addition, many social and cultural changes occurred that encouraged people to question authority and "the establishment" (Pellegrino, 1993). Attempts were made to remove paternalistic, racist and sexist barriers (Levine, 1990). All perceived bastions of power and authority were assaulted (Pellegrino, 1993). Medicine was not exempt (Pellegrino, 1993). Medical practice was seen as an imbalance of power between the paternalistic doctor and the medical establishment on the one hand and the helpless patient on the other (Levine, 1990). Some medical research was seen as having violated individual rights (Levine, 1990).

In this environment of distrust, some philosopher-ethicists who were the first to be known as "medical ethicists," offered ethical rules or principles to protect

the rights of patients in medical research (Levine, 1990; Pellegrino, Siegle, & Singer, 1991). The principles, applied impartially and universally, were those of rights, distance and estrangement (Levine, 1990): the right to be left alone (autonomy), the right not to be harmed (non-maleficence), the right to be treated with fairness (justice), as well as the principles of beneficence (do good) (Beauchamp & Childress, 1989; Pellegrino, 1993). In the mid-1970s, the National Commission for the Protection of Human Subjects codified these principles to protect research patients from abuses (Levine, 1990). These ethical principles, later known as the justice perspective, were so successful that, as stated in Chapter 1, they became equated with medical ethics; they were adopted for use in medical practice and were taught in medical ethics education. The justice perspective was the unchallenged theoretical approach to medical ethics (Pellegrino, 1993).

Perceived Problems with the Justice Perspective

A small group of physician-ethicists, however, concluded that an ethical approach developed for research subjects was not adequate for clinical practice (Pellegrino, 1993). The literature includes the works of at least twenty medical ethicists who highlighted their concerns with the inadequacies of the justice perspective. Their works in a sense, were the precursors to the introduction of the care perspective in the 1990s.

Beginning in the 1980s, a small group of physician-ethicists, including Kass (1990), Toulmin (1981), Churchill (1989), Pellegrino, Singer and Siegler (1991), Jonsen (1988), Gert (1990) and others, identified and described the problems they perceived with the justice perspective approach in medical ethics and in medical ethics education. Although this group of physician-ethicists use the principles of the justice perspective, they outlined some problems with it: (1) the justice perspective was too abstract (Kass, 1990); (2) it created an "ethics of strangers"(Toulmin, 1981, p. 31); (3) it did not "fit"; and (4) it created dissonance between theory and practice in the MedMap.

The Justice Perspective is Too Abstract. Kass, a renowned physician-ethicist associated with the Hastings Center which is the original "think tank" institute for medical ethics, expressed what I consider to be a representative view of this group. In "Practicing Ethics," Kass (1990) argues that the justice perspective is too abstract and rational and that abstract analysis takes the human meaning out of poignant and complicated human situations surrounding complex issues such as sex or dying. He faults an ethic based solely on the rationalistic justice approach which ignores the fact that ethical issues are not isolated abstract problems but are based on human beings who are in deeply significant relationships. He claims that, in medical ethics, this current abstract

approach belies the complex mix of emotional, social, economic and other elements that infiltrate many ethical issues (p. 7). Abstracting and analyzing a problem out of the context of the patient's life creates a distortion of reality (p. 8). Pellegrino, Siegler and Singer (1991) have also expressed concerns that the justice perspective is "too abstract, too remote from the actualities of clinical decisions, too formal and stylized and too neglectful of the character of the medical profession" (p. 8). Pellegrino, although not a proponent of the care perspective, acknowledged the criticism that the justice perspective's approach "ignores a person's character, life story, cultural background and gender" and is "too abstract, too rationalistic and too removed from the psychological milieu in which moral choices are actually made" (1993, p. 1159).

The Justice Perspective is an Ethics of Strangers. Toulmin in "The Tyranny of Principles" (1981, pp. 31-39) addressed his concerns that the justice perspective is so abstract that it in effect becomes an "ethics of strangers." Other physician-ethicists, such as Levine (1990) and Churchill (1989), were also concerned that the "ethics of strangers" is attempting to guide a caring profession. Levine says, the "ethics of strangers," which worked reasonably well in developing policies for the protection of human subjects in medical research, is ill-

suited to the intimate, confidential, trusting relationship between personal physician and patient (p. 27).

The Justice Perspective Does Not Fit. Churchill (1989), Chapman (1979) and Kass (1990), among others, state that the justice perspective ignores common but significant considerations such as human motivation and the 'real issues' that are important in daily medical practice. Kass, for example, asserts the justice perspective "dismisses the things in life that genuinely move people to act including motives and passions such as fear, love, hatred and anger as non-ethical or irrational because they are not simply reducible to logos" (Kass, 1990, p. 6). Churchill, Singer, Siegler, Pellegrino, and Kass all criticize the justice perspective as ignoring the more mundane ethical issues which occur daily in medical practice. Kass (1990) worries that the justice perspective, has a penchant for choosing and attempting to solve extreme, enormously complex problems while largely ignoring the morality of ordinary practice. He believes, that in so doing, the justice perspective has focused on ethical issues which command the limelight and absorb much of the public's attention such as: (1) the withdrawal of life support systems from the critically ill, the elderly or severely-handicapped newborns; (2) whether there exists a duty to warn the lovers of an HIV-infected partner; or, (3) whether we should "harvest" organs from animals (such

as a chimpanzee's heart) for human use (p. 7). Kass indicates that these "media" ethical issues are rarely the day-to-day ethical issues which arise between a physician and patient (p. 8). In fact, he argues they distort the reality of physicians' and patients' worlds (p. 9). Kass asks, "how can we reasonably expect that an ethics for the extreme cases be sensibly worked out even in theory, let alone be successful, when applied to practice?" (p. 7). In addition, Kass (1990), Levine (1990) and others argue that medical practice is unique in many ways and that a medical ethics designed for medical research does not adequately respond to this uniqueness. In the late 1980s, Churchill argued for a distinctive medical ethics that would underscore the uniqueness of the relationship between physician and patient (1989).

The Justice Perspective Creates Dissonance Between Theory and Practice. For several years, a number of philosopher-ethicists and physician-ethicists have been suggesting that the justice perspective is not necessarily the only possible paradigm in the complex maze of medical ethical decision making. Kass (1990), Toulmin (1981), Churchill (1989), Jonsen (1988), Clouser (1988), and Gert (1990), Carse, (1991) and Sherwin (1989) have begun questioning the conceptual foundation of medical ethics. Again Kass expresses a common position: "there is a gnawing suspicion that the impartial demands of justice do not

necessarily override all other moral concerns" [in medical ethics, especially given the uniqueness of the medical profession] (1990, p. 10). George Annas, a law professor-ethicist, suggests that these impartial demands often lead to "actions that pervert the very meaninig of care" (1984, p. 46).

Carse, a philosopher-ethicist, suggests that medical ethics theory is not fully in accord with medical ethics practice (1991). In "Feminist and Medical Ethics," Sherwin agrees that "an appeal to theory and principle do not offer satisfying analyses of the sorts of dilemmas that arise in medical ethics" (1989, p. 68). According to Sherwin, "physician-ethicists commonly rank caring and sensitivity ahead of applications of [the] principles [of the justice perspective] but this tendency is less apparent in the philosophical discussions in the field" (p. 70). Pellegrino acknowledges the viewpoints of medical ethicists who have expressed concerns with the justice perspective. He recently concluded in the Journal of the American Medical Association (JAMA), that medical ethics in the mid 1990s is in a state of flux as some scholars question the justice perspective as the approach to the MedMap. He characterized this period in medical ethics development as "anti-principlism" (Pellegrino, 1993, pp. 1169-71).

Calls for a Different Ethical Approach to Meet the Perceived Unique Needs of Medical Practice

As part of this so-called anti-principle movement, some medical ethicists have gone beyond outlining problems with the justice perspective and are calling for a different approach to medical ethics. They are seeking one which they believe includes the values intrinsic to medical practice - one which is more appropriate for medical practice (Gert, 1990; Jonsen, 1988; Kass, 1990; Toulmin, 1981, and others). In seeking approaches which they believe would not "distort the realities of the physician-patient relationship as it actually exists," Pellegrino states that some medical ethicists began advocating "competing theories of virtue, care and casuistry" (ethics derived from generalizations based on multiple cases) (Pellegrino, 1993, p. 1162). These advocates are, in turn, Pellegrino, who favors virtue theory, Levine, the care perspective, and Jonsen, casuistry (Pellegrino, 1993).

The works of a few medical ethicists who have expressed concerns with the justice perspective, such as Kass and Churchill, lead directly to the care perspective. That is, they include the care perspective by implication without referring to it by name. Their views are compatible with the characteristics of the care perspective. They describe the significance of such things as caring, relationships, and context in the MedMap. They insist that medical ethics theory include all of the values intrinsic to medical practice. They seek a theory

that attends to the nature and dynamics of the particular type of relationship between physician and patient. Furthermore, their works are used as stepping stones by proponents of the care perspective to strengthen the proponents' advocacy position (Carse, 1991; Levine, 1990).

The Care Perspective

Levine (1990), Carse (1991), and Howe (1992) are the medical ethicists who actually introduced the term the "Care Perspective" to medical ethics and medical ethics education. They drew from Gilligan's work and adopted it in their writings on medical ethics and medical ethics education to rectify what they perceive as shortcomings of the justice perspective in medical ethics (Carse, 1991; Howe, 1992; Levine, 1990). Since they referenced only Gilligan, there are gaps on the care perspective in the medical ethics literature and I draw now on the literature from feminist and nursing ethics literature where the Care perspective is defined, explicated and debated.

Definition and Characteristics

The care perspective is a theoretical construct which places the quality of human relationships at the center of ethics (Noddings, 1984). The notions within the care perspective are ages old while its modern explication is quite recent (Carse, 1991). The care perspective can trace its present scholarly articulation to Gilligan who in 1982

postulated a world of moral reasoning in which both a justice orientation and a caring orientation co-existed with equal importance. She claimed that "these perspectives denote different ways of organizing the basic elements of moral judgment; self, others, and the relationship between them" (Gilligan, 1987, pp. 22-23, cited in Carse, 1991, pp. 6-7). Her works sparked much interest in Nursing Ethics and feminist literature where the care perspective has been further defined and described.

Proponents of the care perspective, such as Gilligan (1982, 1987), Noddings (1984), Watson (1990), Carse (1991), Carper (1986) and others, define it as the quality of binding to another human being through relationships and emotional attachments. They see this quality as the central value of the care perspective. "According to the definition of the care perspective, the self is connected to others, responding to perceptions, interpreting events and governed by the organizing tendencies of human interaction" (Gilligan, 1982, p. 13). The care perspective is "an empathetic sense of connectedness to others" (Noddings, 1984, p. 31). The care perspective is based on the assumption that persons are dynamically interconnected and that ethical decision making includes a joint evaluation of the interactions and efforts to preserve the relations (Spinsanti, 1992). The participants in a caring process are persons with histories, values, preferences and

differences (Condon, 1992). Mayeroff, in Caring, describes "a process of relating to someone that involves development . . . in time, through mutual trust and a deepening and qualitative transformation of the relationship" (1971, p. 1).

Other characteristics of the care perspective are the notions of context, covenant and emotional response. In Women and Moral Theory, edited by Kittay and Meyers, (1987) and in other works, proponents such as Gilligan and Noddings, explain the importance of these notions. According to Noddings (1984, cited in Condon, 1992, p. 14), the care perspective requires understanding the person and the context of the ethical dilemma. She worries that this all-important understanding will be obscured if one uses the justice perspective which emphasizes rules, logic and justifications. She asserts that the justice perspective does not correspond well to concrete human situations (Noddings, cited in Condon, 1992, p. 14). Noddings, (1992) says that the care perspective provides an understanding of the interactions of the individuals involved "through narrative descriptions and contextual information" and "not through rigid, barren rules imposed from without and applied uniformly" [which she associates with the justice perspective].

A noteworthy difference between the justice and the care perspective, according to some authors, appears in the language, images, metaphors and moral questions raised

(Cooper, 1991; Gilligan, 1987; Kass, 1990; Levine, 1990). Cooper (1991) notes that the language of the care perspective includes words which denote sensitivity to people, to relationships, to uniqueness, and to details - meant to elicit compassion and caring among human beings. Kass (1990) asserts that on the other hand, the language of the justice perspective denotes rights, rules and universality. The images and metaphors of the justice perspective are words like "hierarchy" or "balance of principles or rules" whereas the care perspective talks about "network or web of relationships" (Gilligan, 1987). The questions change from "What is Just?" in the justice perspective to "How do I respond ethically to this person whom I perceive to be in need?" when using the care perspective (Gilligan, 1987; Levine, 1990).

Other proponents characterize the care perspective using more formal academic terms. According to Baier (1987) and Fry (1989) the care perspective is an integrative, interpretive and inductive approach to ethical decision making. The typical framework of the care perspective is an internal system of justification (Fry, 1989; Noddings, 1984). These justifications are deeply rooted in human nature and are seen in the natural impulse to caring and longing for goodness and are not exclusively to be found with rational argument (Baier, 1987; Fry, 1989; Kittay & Meyers, 1987; Noddings, 1984; Vezeau, 1992).

As with most ethical constructs the definitions of the care perspective are multi-layered and cannot be rendered in a pithy word or phrase. Added to this is the complication that the care perspective is an evolving concept and as yet there is no "ready vocabulary" (Gilligan, 1987, p. 24) or fully agreed upon definition or set of characteristics.

The Care Perspective in Medical Practice

The literature indicates that while the care perspective has philosophical antecedents in recent feminist and nursing ethics literature, its medical antecedents are evident throughout centuries of medical practice. From a careful review of the literature it seems that what is now known as the care perspective has moved through several phases in medical practice. In the first phase it existed for centuries, implicit in medical practice. During the second phase it was omitted from formal medical ethics theory, displaced by the codification of the justice perspective. In the third phase, which is the current phase, the care perspective has been directly linked to medical ethics theory by a few medical-ethicists.

The First Phase: the Care Perspective is Implicit in the Physician's Profession

As touched upon earlier, many proponents such as Gaylin (1976), Noddings (1984), and Gillon (1992) believe that what is now called the care perspective has always

existed because it is an inherent and fundamental precept of ethics for human civilization. According to Gilligan, Noddings, Levine, and Fry, the care perspective is part of virtually every ethical system in every culture, part of the human condition, part of the human consciousness and part of the human conscience. Noddings' writes:

> the caring attitude that lies at the heart of all ethical behavior is universal; it is based on an ethical ideal of myself as caring and as cared for (1984, p. 80); born of a fundamental recognition of relatedness, that connects me naturally to the other (p. 49). One is irrevocably linked to intimate others. Our linkage, this fundamental relatedness, is at the very heart of our being. (p. 6)

Fry (1989) claims that the care perspective is "a view of morality that turns on the philosophical view of caring as a foundational not derivative value among people" (p. 12). She states that in the care perspective "caring is not an outcome but it constitutes ethics" (p. 16).

Proponents such as Levine, Carse, and Carper (1986) believe that the concepts of the care perspective are fundamental ethical tenets that have co-existed with medicine since the dawn of medical practice. Noddings, Levine, and Kass believe that the care perspective is based on the same core values that are currently sought in "good" medical practice and therefore are included <u>a priori</u> in medical ethics. Levine and Carse contend that the defining characteristics of the care perspective such as caring for others and recognizing the importance and uniqueness of the

physician/patient relationship are at the root of medical practice and by inference are essential in the MedMap.

Supporting this contention, there was, and is, strong anecdotal and circumstantial evidence in the literature for the care perspective in the ethical behavior of physicians and in the MedMap. One group of scholars in medicine, Osler (1903), Peabody (1930) and Lazare (1987), incorporated the characteristics of the care perspective in their scholarship and stated their belief that caring was always implicit in medicine. They describe caring as one of the deepest values that give meaning and context to our lives and emphasize the "bonding relationships" which are key characteristics in the care perspective. For example, Peabody, in his classic works on caring, describes "the personal bond between doctor and patient" as follows:

> with the exception of the relationships that one may have with a member of one's family or the priest, there is no human bond that is closer than that between physician and patient/patient's family. (1930, p. 13)

Lazare (1987), a leading medical educator, observes that there are "common elements in patients' relationships to their physicians and to those they love." These common elements include "<u>the existence/establishment of strong and caring bonds</u>" (emphasis added). These bonds are nurtured through "sympathetic attention, interest, positive regard and respect" which create an "atmosphere in which patients feel cared for and respected" (Lazare, 1987, p. 1653). In fact, Kass acknowledges that "certain relationships such as

parent/child, friend and friend, physician and patient, have special moral significance" (Kass, 1990, p. 8). These and similar works are representative of the literature that shows that the thread of the care perspective has been implicit within medical practice and, therefore, in medical education, throughout the centuries.

The Second Phase: Omission of the Care Perspective from Medical Ethics Literature

Nonetheless, the care perspective, despite its long, albeit implicit, connection with medicine, was not included in contemporary medical ethics theory as it evolved in the 1970s and 1980s. This omission was an artifact of the times and may be explained in the following way. The earliest and largest group of Medical Ethicists, including Beauchamp, Childress and Callahan were trained in philosophy, not medicine (Pellegrino, 1993). They developed a theoretical framework based on beneficence, nonmaleficence, justice and autonomy, initially to prevent abuses between relative strangers in medical research. The justice perspective, as it was now known, became firmly established in medical ethics textbooks and formal classroom instruction. From a careful review of the literature, there is no indication that other ethical approaches were considered.

The Third Phase: Proponents Make Connections Between the Care Perspective and Medical Ethics Education

The impetus for the recent interest in the care perspective among physician-ethicists appears to result from three things: physicians are more acutely aware of the ethical questions and tensions in medical practice and the expectation that they solve them (Kass, Pellegrino, Siegler and Singer, Howe); physicians are increasingly aware of the distortions in the MedMap caused by application of the justice perspective exclusively (Pellegrino, p. 1167); and physicians are aware of the growing dissonance between the justice perspective and clinical practice (Jonsen, 1988).

The Care Perspective in Medical Ethics and Medical Ethics Education

Proponents' Views

Levine, a physician-ethicist from Yale Medical School, and Carse, a philosopher-ethicist from the Kennedy Center for Bioethics at Georgetown University, are proponents of the care perspective in medical ethics and in medical ethics education. Their works have become the stimulus for new scholarly discussion in medical ethics.

Levine, in his article "Medical Ethics and Personal Doctors: Conflicts Between What We Teach and What We Want" (1990), was the first to propose the care perspective as an alternative or complementary approach to decision making in medical ethics and medical ethics education. After outlining the present problems with the justice

perspective, he concluded by calling for a systematic exploration of the care perspective for use in medical ethics and medical ethics education. Carse's essay, "The Voice of Care: Implications for Bioethical Education" (1991), complements Levine's. She too calls for systematic and scholarly attention to the modes of thought and action which characterize the care perspective.

Levine and Carse maintain that the care perspective organizes ethical thinking and decision making in a different way and provides another framework essential for examining ethical issues that influence patient care. They believe the care perspective is inherent in medical practice and thus is a natural fit. They argue that the care perspective: (1) has defining characteristics that are easy to recognize and apply in the MedMap; (2) focuses on values inherent in good medical practice and focuses on what is really important in medical ethics - the relationship, i.e., the unique and critical bond, between physician and patient; and (3) can be taught.

The Care Perspective has Defining Characteristics in Medical Ethics. Levine, Carse and other proponents have identified characteristics of the care perspective in order to make it easy to recognize and use in medical ethics and medical ethics education. Levine and Carse believe these characteristics are concrete and clear enough to be ethical tools for physicians in the MedMap. According to them, a person is using the care perspective when s/he:

1. sees a patient as an individual within a context of relationships; recognizes the importance of relationships between two or more people, such as, physician and patient or physician and medical student (Howe, 1992; Levine 1990); and recognizes the existence and importance of complex inter-relationships which Gilligan calls "the web of relationships" (1982, p. 23) and which Noddings calls the network of connections (1984, p. 31);
2. emphasizes an empathetic sense of connectedness to others (Levine, 1990, p. 25); which Noddings described as receptivity, relatedness and responsiveness to others (Noddings, 1984, p. 22);
3. considers the concrete real-life situations of particular persons, rather than idealizations or abstractions (Carse, 1991; Gilligan, 1987; Gillon, 1992); focuses on responding to the individual needs of particular patients (Levine, 1990).
4. is sensitive to and empathetic with a patient's fears, hopes, values and capacities and attempts to nurture and sustain those who are making choices (Carper, 1986; Carse, 1991);
5. is willing to bend or suspend what are known or perceived as universal ethical "rules" in certain

situations to preserve important relationships (Howe, 1992; Levine, 1990).

6. is concerned with reducing tensions between people as well as resolving tensions between competing ethical principles (Howe, 1992; Levine, 1990).

The Care Perspective Focuses on Critical Bonds or Relationships Between Physician, Patient, and Others in Ethical Decision Making. Levine and Carse advocate including the care perspective in medical ethics because they believe it correctly emphasizes the role of human relationships in the MedMap. They believe that the physician/patient relationship, the patient/family relationship(s) and the relationship(s) among the various health care providers and the patient are core considerations for ethical decisions (Levine and Vezeau). In addition, they are also concerned with how ethical decisions affect such relationships (Levine and Howe). Howe, a physician-ethicist and editor of the Journal of Clinical Ethics, in "The Care Perspective and Its Application to Clinical Practice" (1992) observes that the ethics of care requires giving the utmost priority to the relationships between the patient, family and care providers. He writes, "the care perspective directs care providers to explore all other means by which relationships between the involved parties can be preserved" (p. 693). Howe and Levine both note that within the physician/patient

relationship, frequent and sometimes lengthy conversations are designed to reduce tensions among those making ethical decisions.

These same scholars argue that the care perspective is relevant for day-to-day ethical issues (Levine, Carse, Noddings). As proponents they argue that the care perspective, which is grounded in concrete issues, i.e., details, relationships, and problems posed by the patient before them, is well suited to medical practice and the MedMap. Kass, too, argues the physician/patient encounter is always an ethical event or an occasion for the practice of ethical behavior. He states that daily happenings are ethical issues such as: the way physicians speak and listen to patients, and respect and protect their privacy and vulnerabilities. He asks, are physicians too abrupt? too unapproachable? do physicians humiliate patients? do physicians violate confidentiality of the intimate details of the patient's life? He argues that these "mundane" treatment issues are the critical, essential ethical issues of medical practice, they are the ethical issues that are presently being ignored and are the very issues which must be taught in medical education (pp. 5-10).

The Values of the Care Perspective Can Be Taught. Carse (1991) calls for inclusion of the care perspective in medical ethics education. She claims that physicians trained to use the care perspective would be more empathetic and compassionate rather than dispassionate and

distant when facing ethical dilemmas (p. 6) and would also be more sensitive to patients' fears, hopes, values and capacities in the MedMap (pp. 11-20). This she believes would lead to more successful outcomes in medical practice and in the MedMap (p. 22). She asserts that inclusion of the care perspective in medical ethics theory would: (1) assist in developing models and paradigms that are central to the MedMap; (2) impact the content of medical ethics courses; (3) influence the types of ethical issues addressed; (4) define the forms of discourse used; (5) identify the skills and sensitivities to be nurtured in medical professionals; and (6) identify the ethical values and ideas that are articulated in medicine (pp. 12-18). Her work also anticipates the potential convergence of medical ethics education with the broader area of medical education, as she believes that the care perspective can and should be used in all medical education not confined to medical ethics education (p. 22). She states that "medical education from the care perspective would at its best be aimed at developing not only intellectual skills and theoretical knowledge in ethics but the whole character" (p. 22). She concludes by asserting that the skills can be made an integral part of medical education.

To summarize, the proponents state that the care perspective: (1) has historically been included in medical practice; (2) has characteristics that are easy to use and apply in the MedMap; (3) emphasizes the most critical

relationship in the MedMap - the physician/patient relationship; (4) focuses also on details which allow it to fit the circumstances; (5) consists of values that currently exist in good medical practice; and (6) contains values that can be taught.

Opponents' Views

The care perspective which is not universally accepted has both outspoken critics and those who ignore it. The ethics literature includes sporadic, isolated, and sometimes caustic criticism of the care perspective. When scholars do voice opposition to the care perspective, they raise a number of objections:

1. The care perspective lacks substantial philosophical grounding (Pellegrino, 1993, p. 1159). (Fry had noted that Pellegrino in earlier works placed the care perspective in a subordinate role, as a derivative value [1989, p. 16].)
2. The care perspective reflects moral reasoning rather than ethical theory. Opponents do not clarify the distinction they are making between the two (Curzer, 1993).
3. The care perspective may represent a notion in developmental psychology or a communication skill between patient and physician. As such, the care perspective fails to rise to the level and

sophistication of an ethical approach (Puka, 1990).

4. The care perspective emphasizes unique relationships and individual situations resulting in great variations that are not amenable to application of universal principles (Pellegrino, 1993, p. 1159).
5. The care perspective is "adjuvant to, but not a replacement for, ethical principles" (Pellegrino, p. 1159). Pellegrino goes on to suggest that, in order for the care perspective to be included in ethics theory, there needs to be "grounding in a principle or rule to be a trustworthy guide to [the] special ethical decision making" in medical ethics (p. 1159).
6. The care perspective reflects gender-based "feminist" ideas not relevant to general ethical application (Nelson, 1992).

Nelson, an ethicist affiliated with the Hastings Center, in "Against Caring" (1992, pp. 8-15) launched a vitriolic and comprehensive opposition to the care perspective. Characterizing the writings on the care perspective as reflecting "women-centered subjectivity and intuition almost to the point of incoherence," Nelson criticizes the care orientation as lacking a "coherent definition," "theoretical consistency and relevance," and of being "conceptually confused," and "dangerously narrow

in scope" (p. 9). Nelson's arguments, strongly worded and defended, cannot be dismissed. Proponents of the care perspective must adequately address Nelson's concerns if they strive to gain more universal acceptance of the care perspective as a legitimate ethical construct for inclusion in the literature on medical ethics.

Some proponents (Noddings, 1992; Vezeau, 1992), have made counter arguments to Nelson's criticisms of theoretical inconsistency. They point out that Nelson's arguments contain several weaknesses. Both authors argue that Nelson ignored Nursing Ethics articles which were very broad in scope, that she ignored the reality of the world of the practicing physician and that, by so doing, Nelson may have been criticizing views that no one seriously holds (Noddings, Vezeau). Noddings, in "Defense of Caring" (1992, p. 15-18), in language that is very typical of the care perspective, "hopes to persuade" Nelson from her "profound misunderstandings" of the care perspective. Vezeau, in "Caring, From Philosophical Concerns to Practice" (1992, pp. 18-21), claims that Nelson's "critique of caring does not address caring as it exists in practice."

The silent treatment that the care perspective has received is in some ways the most difficult to address and therefore the most influential. Most of the literature in medical ethics to date simply ignores the care perspective. It is not included in medical ethics theory, not debated or

discussed in medical ethics textbooks, raising the question of whether or not the care perspective is routinely taught in medical school classrooms.

The Care Perspective: a Link between Medical Ethics Education and Medical Education

It is interesting to note that the proponents of the care perspective in medical ethics education have begun to receive support from a group of medical educators who write about medical education in general rather than about medical ethics education. As part of a reform movement in medical education, leading medical educators such as Petersdorf (1992), Lazare (1992), Bulger (1987), Hollis (1994), and Fox (1990) connect a caring ethic with medical education. They are advocating a renewed emphasis in medical education to make caring the norm. They want to encourage the training of more humane physicians. In advocating curriculum revision, which would include training in caring and in improving the unique relationship between physician and patient, several suggest that these new educational efforts be included in medical ethics courses (Lazare, Petersdorf, Bulger). This group urges faculty and institutional leadership at academic medical centers to: (1) focus ethical training on the physician/patient relationship and on caring; (2) ensure that ethical standards, expected of faculty, students and residents, are clearly articulated and understood; (3) encourage students to accept responsibility for the ethical

climate; and (4) encourage students to accept responsibility for each other as professional colleagues.

They use words and concepts that are very similar to those of proponents of the care perspective. Petersdorf, past-President of the Association of American Medical Colleges (AAMC), in his article "Are we educating a medical profession[al] who cares?" believes that "students want very much to be caring physicians but we do not do much to help them" (1992, pp. 1338-1341). Lazare suggests that through medical ethics education, physicians-in-training can be instructed in ethical matters and in developing bonding relationships between physician and patient (1992, personal communication). Bulger, in his book <u>In Search of the New Hippocrates</u> (1987, p. 93) states that "by refocusing medical education on caring communications and community we might well reinvigorate our sense of educational direction." Other recent literature, such as the panel report entitled "The General Professional Education of the Physician (GPEP Report)," the Balint literature, and works emanating from the Kellogg Foundation, have addressed the physician-patient relationship. They have called for and/or described innovative approaches aimed at developing caring in the physician-patient relationship as a humanistic quality--but not specifically as an ethical concept.

Hollis in "Caring: A Privilege and Responsibility" (1994) also connects caring, medical ethics and medical education. Without using the words, the care perspective, he points to "the need to renew the commitment to caring through more course work in ethics." He insists "this means we must endow caring with a tangible value" (p. 1). Fox, too, uses concepts of the care perspective. In "Training in Caring Competence" (1990), she discusses what she calls the perennial problem in medical education: "educators repeatedly call for virtually the same rediscovered principles of caring compassion" (p. 203). She says,

> Although the language in which these concerns and affirmations have been expressed has varied somewhat from one decade to another, there is one preoccupation - one major theme - that is central to all of them: the importance of caring for and caring about patients with competence that is compassionate and compassion that is competent. (p. 202)

She questions the "highly analytic, logico-rational way of thinking and viewing the world" in medical thinking and says "so obdurate are these tendencies [to value science and to dismiss non-science] that they do not yield easily . . . to attempted reforms in medical education" (p. 203). She states that all reform seems to circle around virtually the same rediscovered principles of good physician-hood and medical care. Yet she maintains that when medical educators ". . . plan or talk about reforming curriculum and training programs they rarely speak of such matters or take them into account" (p. 203).

Reflecting on the connection between medical ethics and medical education, Kass concludes

> beneath the distinctive issues of medical ethics lie the deepest matters of humanity. We need to think less about doctrine and principles and rules to govern behavior and more about (medical) education and what sort of people (physicians) we produce. We need to think about how to encourage and enhance the formation of certain attitudes and sentiments. (p. 11-12)

Summary

This review has shown the connections in the literature between the care perspective, medical practice and medical ethics education. Historically, the care perspective has been absent from medical ethics theory. The literature shows a growing interest among some physician-ethicists to formally incorporate the care perspective as an approach to the MedMap. It is expected that the literature on the care perspective will continue to grow steadily to reflect on-going changes in medical ethics and medical education. This study will add the voice of the physician-educator who teaches medical ethics to medical students to the scholarly literature on the care perspective. This voice needs to be heard since physician-educators have significant impact on the content of medical ethics courses and educational approaches.

C H A P T E R 3

RESEARCH METHODOLOGY

Problem Statement and Purpose of the Study

After many years of being omitted from the theory of medical ethics, the care perspective is beginning to emerge in discussion in medical ethics. But to date, the discussion of the care perspective in medical ethics has been by medical ethicists and to the best of my knowledge, has been largely confined to theoretical issues. Work to date on the care perspective, does not tell us how physician-educators view or use the care perspective in medical practice and/or in medical ethics education. Yet it is physician-educators who have the most profound impact on the content and focus of clinical education and medical ethics education. It is they who are molding future generations of physicians and in doing so are setting the climate for medical practice. The lack of knowledge about what practicing physician-educators think about the care perspective in medical ethics and medical ethics education is the problem to be explored in this study.

The Design and Justification for the Study

This study is designed to gather information through a series of in-depth interviews with a group of physician-educators using qualitative methodology. Given the problem and purpose of the study, I considered a group of

physician-educators who teach medical ethics in an academic medical center (AMC) to be the best source of information and considered qualitative methods an appropriate choice for the exploration and description of their views.

Qualitative research methodology was chosen as being appropriate for exploring and then describing important common patterns from the perceptions of physician-educators in medical ethics education. This methodology allows researchers to explore relatively unstudied subjects. Lincoln and Guba (1985) claim that qualitative methodology is the preferred research strategy for obtaining the broadest range of information and perspectives on a subject of study. It is discovery oriented (Lincoln & Guba, 1985) and seeks to "find out what is there" (Patton, 1989, p. 61) making it suitable for exploratory research. This methodology yields descriptive data about people in their natural settings. By using their own words to describe their concrete experiences and to explain what these experiences and concepts actually mean to them, it lets the participants in the study lend meaning to and make sense of the facts of their world (Benner, 1985; Munhill, 1993; Van Manen, 1990). Scholars note that qualitative research is often the initial step in generating data upon which follow-up empirical studies are based (Patton, 1990).

Lincoln and Guba (1985, 1989), Marshall and Rossman (1989), Munhill (1993), Benner (1985), Van Manen (1990), and Crabtree and Miller (1992) are among many who have

described the unique design features that are characteristic of qualitative methodology as well as the rationale for its use. For this particular exploratory study, Doing Qualitative Research: Multiple Strategies: (Crabtree & Miller, 1992) was especially helpful since Crabtree, a medical anthropologist and Miller, a physician anthropologist, are familiar with both qualitative methodology and academic medicine.

Methodology

Research Site

A public academic medical center (AMC) in the northeast region of the USA was selected as the research site for convenience and access from among the 123 AMCs. This setting provided the opportunity and ability to explore with physician-educators aspects of their medical practice that were associated with medical ethics and medical ethics education. Although generalizability is not a claim for this qualitative study it is important to note that this site is typical of the 123 medical schools in the United States; all require a common core curriculum and the LCME requires that the curriculum include medical ethics. As stated earlier, medical practice and medical education are closely intertwined at AMCs. As the physician-educators are treating their patients, they are concurrently instructing their students so that their medical practice is also their teaching material.

Access and Role Difficulty. As a student affairs administrator at the AMC selected as the research site, my experience and employment helped with issues of access and candor but required special care. Over the years, I have established professional relationships with the curriculum dean and with physician-educators based primarily on a mutual commitment to medical education. My researcher's role as a doctoral candidate engaged in dissertation study that looked at approaches to the MedMap with an interest in the care perspective was known by the participants. I obtained permission from the AMC's ethics committee to review the written documents for the purpose of selecting the initial participants in the study.

Participant Selection

In deciding which of many sampling strategies to employ in this qualitative study, I decided to follow the guidelines of Patton (1990) and I deliberately selected a purposeful sample. Patton (p. 33) states that qualitative inquiry typically focuses in depth on relatively small samples selected purposefully to obtain information richness. Crabtree and Miller (p. 39) defend the use of a purposeful sample on the basis of seeking to understand a particular group of individuals particularly well. I needed to find a group of physician-educators with some familiarity with the care perspective. I did not need to

know what they thought of it but did need them to be familiar enough to have a conversation with me. Participants were chosen purposefully because they are knowledgeable about the general subject area, (Patton, p. 182) in this case, of the MedMap and may have some familiarity with the care perspective.

In determining the sample size for purposeful sampling, I was guided by Lincoln and Guba (1985), Marshall and Rossman (1989), and Patton (1986) to sample to the point of redundancy or theoretical saturation. Since "experience has shown that 6-8 data sources or sampling units will often suffice" to reach this point (Lincoln & Guba, 1985), I obtained 18 potential data sources and drew sampling units from among them using the following procedure: First, I reviewed documents of the JCMS Ethics Committee. From the records of deliberations of ethics consultations in 1991, I identified three individuals who both teach medical ethics and who appeared conversant with the concept of the care perspective as they used expressions such as "the ethics of caring" or "caring as an ethical behavior." They were the first participants interviewed for this study. Following the interviews, I asked them to identify additional physician-educators who were also familiar with the care perspective. They identified fifteen individuals, all of whom taught medical ethics, were familiar with the MedMap, and had some familiarity with the care perspective. From these fifteen,

I selected the next participants alphabetically. After conducting interviews with a total of ten individuals, the information was becoming redundant and appeared to have reached theoretical saturation.

To provide brief background information on participants for general interest but with no intention of analysis, I gathered data through a brief questionnaire on age, gender, faculty appointments, medical specialty and average number of years in practice, training background, practice characteristics, and professional and educational activities in the area of medical ethics.

Research Questions

For this exploratory descriptive study on medical ethics education, information was sought on medical educators' perspectives and interpretations of the care perspective as an entity. Furthermore, questions pertaining to the utility and appropriateness of the care perspective in influencing the medical ethics education process were probed. The interview questions were open-ended and semi-structured and served to guide rather than dictate the interview process.

The following questions are examples of those used in the interviews beginning with the exploratory ones of the first session and ending with the more specific in the last session.

1. How do you make decisions about ethical matters in your practice?
2. Think of a patient or student you are presently treating or teaching. How would you describe your MedMap in this situation? How did you make the medical ethical decision that you described?
3. Describe any recent experiences which illustrate what you have just said.
4. Describe any experiences that contradict anything you have just said; OR Whom do you know who thinks very differently about this and describe what they might do?
5. Describe what the care perspective means to you as you deal with an ethical problem.
6. How does this fit into your teaching?
7. What do you view as the distinguishing features of the care perspective in the MedMap?
8. What experiences, if any, have you had with the care perspective in the MedMap?
9. What are the implications of the care perspective for medical ethics education?

I approached all first interviews with this series of potential questions in hand as a stimulus and/or to keep the interviews focused on the general subject. These questions were meant to encourage conversation, and to explore areas for further probing. Questions used for second interviews had been generated from the first

interviews and were designed to probe an area more deeply to clarify issues (for example: What is the difference, if any, between empathy as you have defined it and the care perspective?). Although the questions were not designed to force participants to cover all areas, by the time both interviews were concluded most of the same questions had been posed. During the second interview some participants reported that they had thought about the issues since the previous interview session and had something more to add.

Data Collection Procedure

The interviews were conducted in the following manner: meeting each participant three times. The first meeting was a brief twenty-minute orientation; the second and third were each full hour interviews. The process of the in-depth interview used in this study followed closely the methodology developed by Crabtree and Miller (1992) and Marshall and Rossman (1990). The process included: (1) orientation and overview, (2) focused interviews, (3) review with participants, and (4) closure.

Orientation and Overview. Prior to the first meeting, faculty members were contacted by telephone, the purpose of the study and time frame were briefly discussed, and participation in the study was invited. Confirming letters were sent, which briefly reiterated the purpose and method

of the interviews. Interviewees were also sent a brief form designed to obtain demographic information to be returned prior to the first meeting.

At the first meeting, the study was again described and discussed in detail, and written consent was obtained for audiotaping the interview. This first session was designed to establish common ground and common definitions and to stimulate thought about the MedMap and about medical ethics education.

Focused Interviews. The two interviews were scheduled for one hour, approximately one to two weeks apart and were conducted in the participant's office. Conducting multiple interviews with the same participants provides one way of controlling bias as this allows patterns to emerge and prevents the interpreter from emphasizing an idiosyncratic episode that does not recur (Benner, 1985).

During these meetings the participants were interviewed using semi-structured, open ended questions (Crabtree & Miller, 1992). Concrete examples, anecdotes, vignettes and personal experiences were requested and assurances of confidentiality for the participant and for any person(s) they described in the interview were given. On these separate occasions, Researcher attempted to provide (1) adequate time, (2) an atmosphere of trust, and (3) a natural setting which according to Benner (1985),

Cooper (1991), and Parker (1990) permits a full story to emerge and encourages participants to reflect on the meaning of their experiences.

Review with Participants. I sent a copy of the original transcripts to each participant to be reviewed for accuracy. At a later date, I sent an edited compilation of the participants' quotes and stories with major changes marked for comparison. Participants were invited to review the edited quotes and stories and approve, or indicate if they preferred that I not use them. The edited versions were returned with approval to use. This review provided participants the opportunity to review the accuracy of their own material (i.e., what they had said in their quotes and stories) but did not involve them in reviewing the version that included my interpretations and the meanings I assigned to them.

Closure. One week later a thank you letter was sent that reflected some of the interviewees' interests. As some ideas for general education reform seemed very important to the participants they were included in the thank you letter as feedback with the recommendation that they be submitted to the educational policy committee or the curriculum committee.

Field Notes and Memos. After each interview, I wrote field notes which included several content areas: a subjective description of the events of the interview; a description of the setting, the mood and degree of rapport

established; and in some cases, some follow up questions to ask of the participants. While transcribing the interviews, I recorded my own first reactions to "capture shifting connections" between the data. Following the transcription, I listened to the tapes again for flavor, tone and emphasis, making brief notes of my observations and reflections. I referred to these dated memos as data while working on the data analysis.

Modifications from the Original Design

As accepted in qualitative research, I made several changes from the original design. Crabtree and Miller (1992), Lincoln and Guba (1985), and Taylor and Bogdan (1984) point out that in this type of methodology, the research design can be modified as the study progresses. I made modifications in the scope of the study, in a feature known as "triangulation" and in the scope of the analysis.

During the proposal stage, I originally intended to use a variety of data sources, a concept that is sometimes known as triangulation of sources and methods which is designed to control bias in qualitative research (Denzen, 1978; Glaser & Strauss, 1967; Lincoln & Guba, 1982; Munhill, 1993). My plans were to include participant observation of an AIDS Symposium and review of documents of an AMC's Ethics Committee's consultations. Initially, my plans for analysis were to summarize this raw data and to conduct a thorough analysis of the observations and of the

documents seeking themes and patterns as previously described for the interviews. In the initial design the units of analysis were to be individual faculty interactions (from observations) and sentences (from document review). Due to time and resource constraints, I was unable to do a comparable, thorough analysis and modified the scope of the study limiting it to the interviews. Consequently I did not use "triangulation" as a method of verification.

Data Management

Several logistical steps were planned for data management and data reduction prior to, during, and in the follow up to each interview. Because the interviews were conducted overtime, several steps were underway simultaneously.

Logistics prior to inquiry began with plans for organizing the collection and storing of data. I prepared folders for each participant, designed a check list, and attached it to the cover of each participant's folder indicating the present stage of the inquiry. The list included the following data elements: names of original computer file, edited file and compilation file, participants' name, code name, date of interview, location of interview, level of analysis completed, and follow up action.

Logistics during the inquiry began with audiotaping and transcribing the interviews verbatim on a word processor. I later edited and compiled additional versions. I double-spaced the text with wide margins to allow for notes; and numbered each line sequentially. I preserved all transcriptions on a floppy and a hard disk and printed and stored an original hard copy in the participant's folder. Transcriptions were identified by colored paper. A snippet of colored paper corresponding to color coded copies of participant was affixed to the original folder so themes, quotes and other data could always be properly identified and attributed even when moved (see appendix). Multiple copies were needed since data could fit into more than one category. Thus, for each transcript there are also separate files with only those segments pertaining to a particular code/theme/pattern.

I used printed versions for textual analysis of data, listened to the tapes again, compared them with a hard copy of the transcription and made corrections when errors were found. I considered both (1) hiring a transcriber to convert audiotapes to word processed text and (2) using a computer system for analysis but decided that at this stage it was important to develop expertise in the process. In any future research, I will use this type of technical assistance.

Data Reduction. Data reduction is both part of the logistics in managing the data and the first phase of the

analysis. The texts of the interviews consisted of approximately 500 pages of verbatim data. I read and coded the transcript, underscoring key words, phrases, repetitive words, phrases or unusual expressions. Data that was beyond the scope of this inquiry (ex. ideas, strategies and techniques for general educational reform) was appended to a newly created file entitled "further study"). Data from the original transcription that was deleted was noted in the edited version. I used the "blacklining" technique used by lawyers in legal texts to denote deletions and additions to the transcript. Participants were given copies of both the original and edited text, asked to review the material and encouraged to restore any deleted text when they felt the deletions altered their intent.

Data Analysis

I was collecting, coding and analyzing data simultaneously. Conducting multiple activities of an interactive and iterative nature, simultaneously, is characteristic of much of qualitative research (Crabtree & Miller, 1992; Munhill, 1993). An overview of this interactive and iterative process that I used is as follows: (1) conduct interview, transcribe tapes and begin abstracting using memos; (2) listen to tapes for impressions and nuances; (3) re-read transcripts, highlighting significant words, phrases; (4) identify categories, cluster groups and themes; (5) repeat steps 1-4

with next interview until reaching thematic saturation; and (6) develop the findings into a conceptual framework.

According to Marshall and Rossman (1989) and others this design requires systematic and intense analysis through multiple iterations, to detect the meaningful units or parts that lead to the identification of themes, patterns and interrelationships between ideas. Three levels of analysis were utilized. In Level 1 analysis working with raw data, I selected and coded words or phrases, interview by interview, selecting words or phrases from the transcripts that seemed potentially significant. I noted the frequency with which something was said, occurred or was reported and the intensity or emphasis surrounding the participants' comments and if the topic had been included by more than one participant. Certain words appeared with regularity, frequency or emphasis and/or were common across interviews. For example, "mechanical exercise," "bonding relationship," and "ethic of care" were used often. With probing, I learned that participants used certain terms interchangeably, for example, the ethic of caring, care ethic, and the care perspective. I adopted one term (in this case, the care perspective) consistently for clarity.

In Level 2 analysis, working with clusters of words and phrases, I searched for common elements, that is, notions that were mentioned repeatedly, which then fell into categories, patterns, trends and themes. I annotated

and color coded the text. One of my basic aims was to determine what patterns the participants considered important enough to bring up (as recommended by Munhill, 1993, p. 121). The analysis of the text involved many iterations and included the collection of additional data until no new patterns emerged.

In Levels 1 and 2 analysis, I used open coding, that is, coding into as many patterns as possible to ensure full theoretical coverage (Lincoln & Guba, 1985, p. 233). Thus at the conclusion of level 2 analysis there were eight broad topics that were common to all the participants. For example, I noted that participants had identified three types of distinguishing features that they believed to be characteristic of the care perspective. Other patterns emerged in a somewhat similar fashion: for example, one topic developed from the frequent and significant responses about the physician's own relationships with the patient, the student or other health care providers.

One interview was coded through Level 1 and 2 analysis by a fourth year medical student from another institution with a masters degree in medical ethics. She served as an external, unbiased check on my coding system. Her coding results essentially concurred with mine. The patterns which emerged from her work were very similar to mine (she identified ten major topics; I identified eight because I had treated the three care considerations as one topic.)

Only one interview was coded by this student due to time and financial constraints.

In Level 3 analysis, the findings were developed into a conceptual framework based on four very broad themes which roughly corresponded to several focused but open ended questions asked during the interviews. In addition I grouped stories together thematically with the major topics. As suggested by Benner (1992) the thematic structure was supported by paradigm cases or exemplars, which I simply called stories. (A story is one example, sometimes from many, which has been chosen because it encapsulates best the point being made.) I adopted this technique because participants often gave examples from their clinical practice to illustrate their points.

After analyzing each interview through these three levels, I focused on verifying and articulating what appeared to be happening, using data from all interviews to cross check and validate my tentative findings.

Throughout the study I tried to strengthen the trustworthiness, credibility, dependability, confirmability, consistency and neutrality of the study - characteristics that Lincoln and Guba (1985) and Kuzel and Like (1991) say are more in keeping with the nature of qualitative research than validity and reliability for demonstrating methodological rigor. For example, to strengthen the trustworthiness and the confirmability of the findings I used multiple interviews with the same

participant over a period of time, repeated the analysis through several iterations and submitted the data to the participants for their review. To increase the dependability, the credibility and the neutrality of the study, I made a very conscious attempt to be true to the text and to not read meanings that were not supported by textual evidence. To provide consistency, I used the same general open ended questions with each participant and a consistent three-level analytic approach to the parts and to the whole text.

Reporting of Findings

The findings are reported in thick, rich, narrative descriptions using the participants' own words. Since the intent of this study was to provide the participants' views in their own words, the categories were broad in nature and the findings include many verbatim statements. However, there is always some editing needed to render the spoken word into grammatically correct written communications. Abrupt transitions, changes in thoughts midway through sentences and awkward wordings were all changed into more idiomatic language.

I was concerned that too much editing and that over analysis would render the stories less meaningful or out of context. To preserve the freshness and immediacy of the participants' original commentary, I have attempted to retain as much of the language and imagery as well as the

idiosyncracies of the stories and the storytellers as possible.

Some details about the participants were changed to protect their anonymity but the descriptions at the end of this chapter are mostly real in that they try to capture the flavor of the personality and past experience of each participant. The stories and comments attributed to a particular participant were either verbatim, were edited as described above or were a synthesis of statements from various points in either the first or second interview or both. This was done for ease in reading and for clarity in presenting materials. Participants' responses are cited by a coded initial. In places where I have used the participants' words verbatim I have used the participant's letter code followed by quotation marks. In places where I have synthesized their comments and stories, drawing from different parts of the interview, even from different interviews to present a clear picture of a participant's views on a specific subject, I have used the participant's letter code followed by a colon. In the instances where I edited, reconstructed or synthesized their words, I remained faithful to their thoughts and expressions and I sent an edited text to the participants for an accuracy check. In some instances, the comments or stories of several participants were very similar and one was selected as representative.

The stories themselves are significant because as Benner observed, "common meanings become apparent when narrative accounts of diverse clinical situations are given with the intentions, context and meanings intact" (1984, p. 6). I adapted the notion of stories, as well, to meet Crabtree's guidelines in "preserving the idiosyncratic, personal details of the participants' experiences . . . and preserving their styles and approaches" (1992, p. 200).

Bias

Throughout the study, I minimized assumptions in order to be as free as possible from conceptual presuppositions and other biases. The researcher admits to a strong bias toward competent, practical medical ethics education programs. Additionally, the researcher's curiosity about the care perspective had been aroused by articles in Nursing Ethics journals. As an educator, a member of the general public, and as a potential patient with definite views on patient care and medical ethics, the researcher thought the care perspective was a medical ethical approach that merits study. A number of books, journals, and other sources were examined as background for understanding differing views about the care perspective in medical ethics. Due to the recent advent of the care perspective as a formal approach into modern medical ethics, the researcher adopted a broad discovery approach to the research and focused on discovering "what is happening?"

I am aware that almost everyone, myself included, has very strong emotions about and personal interest in subjects involving medical ethics, such as, among others, the right to die. I did not want the interesting ethical dilemmas to distract me from the examination of the care perspective approach to the MedMap in medical ethics education. To manage the potential for bias related to the subject matter itself, and to my own area of interest, I did a range of things.

To minimize bias in terms of data collection, I carefully worked from taped interviews, from typed transcripts and from printed summaries that I submitted to the participants for their review of the accuracy in reporting their statements. These statements and stories reflect their concrete experiences. To minimize bias in terms of data analysis, I used two outside resources. First I conducted and analyzed one practice interview that was then critiqued by a faculty member from the Graduate School of Nursing. This person has expertise in both qualitative research and the care perspective and was instructed to seek any signs of bias on my part in conducting the interview or analyzing the data. Next, as previously mentioned, I had one interview coded through Level 1 and 2 analysis by a medical student. Both of these sources provided feedback that was intended to minimize bias on my part.

Limitations

This type of study has definite limitations. It is labor intensive. A great amount of data must be gathered that must be distilled. The qualitative methodology and purposeful sampling strategy do not allow for statistical generalizability. Despite this fact, findings are expected to accurately reflect the perceptions and experiences of some faculty and students at certain medical schools in the Northeast. Again, although not universalizable in one sense, in another sense the findings may echo the experiences of others. This phenomena of recognizing one's own experiences in someone else's words was noted by Munhill who wrote "My own experience is the possible experience of others and vice versa" (1993, p. 62). This study probably cannot be replicated. Still, the researcher assumes it will provide a useful starting point in theory generation or in stimulating empirical research.

The Research Setting: JC Academic Medical Center

The JC Academic Medical Center (JCAMC) is one massive, somber, dark-gray granite building with a commanding view of a northeastern city. A publicly funded Medical School (JCMS), University Hospital, Graduate Schools of Nursing, of Allied Health and of Biomedical Sciences comprise this AMC. 5000 people are employed here, making JCAMC the largest employer in the city. Entering through the medical

school lobby, one is aware of vital activity. Doctors, nurses and students walk briskly through the corridors.

In contrast to the physical durability of the building is the ever present awareness of the fragility of life. There is the repeated pulsing of life as the loudspeaker bleats, "There is an urgent need for all types of blood. There is an urgent need for all . . ."

The participants' offices provided marked physical contrast to the rest of JCMS which has bland gray and brown metal furniture and gray tile floors. The offices included personal effects which suggested the personalities and status of the participants. The participants' offices ranged from stark simplicity to organized chaos (with piles of papers, articles and projects strewn on every surface including the floor) to one large luxurious room furnished with deep rose carpeting, soft upholstered chairs and sofas, lamps, mahogany executive furniture and appointed with personal accoutrements and art work.

Study Participants

Dr. A is a female cardiologist in her 40's. She graduated magna cum laude from Vanderbilt University and with honors from the Medical College of Virginia. She has been in practice for twenty years. She is co-chairman of her department - one of the few women to hold such a position. She practices in a teaching hospital adjunct to

a medical school. She has taught medical ethics for one year.

Dr. B is a male primary care physician in family practice in his early 40's. He focuses on Family Practice. He is very concerned about medical services for minorities. He graduated from Vassar College and Columbia University College of Physicians and Surgeons. He has been practicing for twelve years and has been participating in medical ethics education for three.

Dr. C is a male cardiologist in his late 40's who serves on the ethics committee. He graduated summa cum laude from Harvard College and Dartmouth Medical School. He has been in practice for 15 years. He is considered to be a visionary in the area of medical education. He is a proponent of more compassionate healing methods.

Dr. D is a female pediatric surgeon in her mid 50's, educated abroad and at the University of Mississippi Medical School. She practices and has lectured and taught all over the world. She has been on the staff for 25 years.

Dr. E is a male neurologist in his 50's who serves on the ethics committee. He holds many graduate degrees and has been engaged in research and medical education for 25 years. Ten of those 25 years were served at the Center for Disease Control in Atlanta, Georgia. He is a graduate of Yale University and the University of Texas Medical School. He is deeply concerned with ethics training.

Dr. F is a female neurologist in her mid 30's. She has been practicing for five years. She is a graduate of the University of Arizona and Yale Medical School. She was the only participant to have had formal training in medical ethics.

Dr. G is a male physician in orthopedic medicine for 25 years. His father, grandfather and daughter are all physicians. His wife is a nurse. He graduated from the University of Kansas and Johns Hopkins medical school. His interest in formal medical ethics has been quite recent.

Dr. H is a male who practices in Family Medicine and psychiatry. He is in his early 40's. He graduated from the University of Massachusetts and Johns Hopkins Medical School. He has joint appointments in Family Medicine and Psychiatry and has been in practice for 10 years. He has been teaching ethics for seven years and serves on the ethics committee.

Dr. I is a female primary care physician in her 40's. She graduated from Swarthmore College and Duke University Medical School. She practiced medicine for five years in Appalachia before joining the teaching staff. Of the respondents she was the most knowledgeable about the theoretical aspects of the care perspective.

Dr. J is a minority female in her late 40's. She has been practicing in family medicine in an inner city clinic for 15 years. She graduated from Stanford University as a

nurse. Later she graduated from the University of Iowa Medical School.

Participants and Case-Stories

The ten participants teach medical ethics courses to the JCMS medical students. Three of the ten participants are members of the Ethics Committee. Of the ten participants, five are men, five are women. Two participants are classified as belonging to recognized minority groups. Four participants are family practitioners or in general medicine practice, six are specialists. It is unknown whether participants were representative of medical ethics educators at JCMS. Compared to the total faculty at JCMS, however, participants were younger; there were more women, more generalists and more ethnic minorities.

All ten participants were conversant with the care perspective - consistent with the criteria for participant selection. Some participants used the term the care perspective. Others used terms, such as "ethic of care" or "the care ethic"; however, for ease in reading, I have used the term the care perspective uniformly throughout. Participants initially responded to questions in their "public voice" and gave formal lecture style responses; but when asked additional questions they responded more conversationally.

All participants used real cases to illustrate their views on the Care Perspective. In addition to their choice of cases, they carefully reported dialogue between the physician and patient, the physician's musing on the issues and in general, the language used. I, therefore, included their case-stories to indicate how they understand and use the Care Perspective. The stories and commentary focus on medical practice and patient care. At first the connection between medical practice and medical education may be unclear, but as stated earlier, at academic medical centers, medical practice and medical education are inextricably linked. Physician-educators instruct medical students as they treat patients. For this reason, while many of the commentaries and stories are explicitly about an individual patient's medical treatment, they are also about teaching medical ethics to medical students.

Participants described in their stories and commentaries what they considered to be ethical problems and decision-making and I report them as such. I made no judgment as to whether the situations fell within the realm of ethics. Frequently the participants prefaced or concluded a story with a notion similar to the one expressed by Dr. A. Dr. A stated that "at first glance what I am saying appears to be both common sense and commonplace. It may not seem to an outsider to be about medical-ethical issues but to me it would be unethical to ignore this person or this situation."

Presentation of Findings

Findings will be presented in three chapters. Chapter 4 presents the participants' views on the characteristics of the care perspective. Chapter 5 describes the participants' experiences with the care perspective from their words and stories. Chapter 6 describes participants' views, first, on the role and place of the care perspective in medical practice and second, in medical education. Chapter 7 includes a summary of the findings, conclusions and recommendations for further study.

C H A P T E R 4

DISTINGUISHING CHARACTERISTICS OF THE CARE PERSPECTIVE

Three Common Characteristics

Participants were asked to describe what they considered to be the distinguishing characteristics that defined the care perspective in the MedMap. Each described at length characteristics that they associate with the care perspective that for them distinguish the Care Perspective from other ethical approaches. There were three that were mentioned by at least eight of the participants. These are:

1. treating the patient or student as a human being.
2. understanding and respecting relationships.
3. learning about the context of the patient's life.

One participant, Dr. G, called these "care considerations." Several participants noted that the characteristics were closely connected, that one characteristic led into another and that two or more were often blended together. For example, Dr. J stated that once she really began treating patients as people, then she started thinking of them in terms of people with whom she was in a relationship and she started taking into consideration the context of their situation. Participants, in addition to identifying these as distinguishing characteristics, included them in most of their comments or stories.

Treating the Patient as a Person

All ten participants stated that they believe the care perspective emphasizes treating the patient as a person. They consider this characteristic to be fundamental to the MedMap. They further believed that the care perspective's emphasis on this point made it unique among ethical theories with which they were familiar. Participants mentioned the need, as elementary as it may sound, for physicians and medical students to recognize their patients as people with whom they will interact, discussing complicated, emotionally charged and deeply personal issues. When queried, each stated that s/he had not always done so. (Participants describe their evolving ethical awareness in Chapter 5.) They further report that this elementary premise is not a given for physicians. (This issue is explored in Chapter 6.)

Two participants, Drs. B and J, stated that ethics, which they believe is concerned with the study of what is intrinsically right and wrong as applied to actions in human behavior, has little meaning for them until they see their patients as people. The other eight participants used words or expressions like "pillar," "building block," and "essential to the ethical process" when describing this distinguishing characteristic. None believed ethical decision making could go forward without express recognition of the human face of illness. All respondents

stated their belief that medical ethics involved balancing the conflicting issues of disease against personhood.

According to participants, the need to teach physicians to recognize patients as people arises from modern medical training. All participants described modern medical education as somewhat dehumanizing. More particularly, they described medical training as teaching physicians and medical students how to diagnose and treat illness in the human body in an objective, abstract way, using a wide array of sophisticated drugs, techniques and technologies. As important and as encompassing as the study and treatment of disease are, participants noted time and time again that physicians are primarily treating people - people with illnesses. According to Dr. B, the role of medical ethics education should be to make all physicians aware of the person before them whom they are about to treat. Dr. G stated: "I always connect my major ethical approach with the Maimonides oath (an alternative to the Hippocratic Oath) which urges us to "remember that the patient is another human being who is suffering and in pain."

The following three stories and other commentary illustrate the participants' awareness or growing awareness of the connection between the person and the patient seeking medical care. The first story is told by Dr. B, a male primary care physician in family practice who has been involved in medical ethics education for three years and

who is concerned about medical services for minorities and women.

THERE IS A REAL PERSON HERE. Dr. B's Story:

In my fourth year of medical school in a family medicine elective I did a write up on a patient. There is a general rule that the first step in writing up a physical exam is to describe the patient using the traditional format, i.e., the patient is "an 83-year-old white male appearing younger than stated age." I did not like this approach as it tells very little. Instead I always described my patients as the real people they are. In trying to capture this person I wrote: this patient is an elderly, crusty, old farmer. In my two or three sentences I wanted you to, and believed you could, actually picture this person sitting in front of you. I did it on purpose. This wasn't a generic 83-year-old white male to me.

That's the way I've always written my write-ups. Nobody had ever commented on it though. I wondered if anyone noticed - or cared. However, this time, my preceptor (faculty physician) said to me, "I know who you are talking about. I know this person." We then talked for a few minutes realizing that we both had in some ways bonded

with this individual. I also had the realization of "Wow, my preceptor read what I wrote. He can see this person." It was a validating experience. I try to teach my students to be aware that they have real people in front of them who have had a life before, during and after their encounter with the health care system.

Dr. F, the youngest participant, was the only one who had had any formal medical ethics education. As a medical student she had taken a required ethics course (three four-hour sessions), which focused on four ethical principles of beneficence, non-maleficence, autonomy and justice. She felt, nonetheless, that recognizing the patient as a person is, above all else, fundamental to what she understood medical ethics to be in her practice. She asserts that patients and medical students welcome being treated as people. She clearly feels that patients' families and friends welcome it, too, even if their loved one is, in many senses, no longer alive. Dr. F, in describing her own ethical approach as a neurologist, states that "even with comatose patients, I recognize that there is still a person here."

HE IS STILL A HUMAN BEING. Dr. F's Story:

One of hardest things I face in dealing with terminally ill patients is that even though I may

think that the patient is brain dead, he is still a human being. I am adamant about treating all of my patients as persons. As part of my respect for human life, I treat even the comatose patient with respect and caring. I am very careful to address the patient by his name and make an effort to communicate normally with him even though I doubt that he can hear me. I want the medical students and residents doing rounds with me to understand and remember that this patient is a person still, even though he may not be able to absorb and/or respond. I also accord the same caring and respect to his/her loved one.

Dr. G, a male orthopedic specialist with long family ties to medicine but quite recent interest in medical ethics, stated:

> . . . when I frame the issues in any clinical decision, I pay attention to the person and consider that fundamental to my ethical approach. I've found that even if a patient comes with an acute or treatable problem, s/he is also often coming for something beyond that. I think once you know your patient you find that his non-medical needs, as a person, can be as important as his strictly physical medical needs as a patient. I believe in order to treat patients

ethically I must see the person behind the illness. Then I must act accordingly. If I take this simple step, then I can say I make decisions about the medical care of my patients in an ethical manner.

I SEE THE PERSON WITHIN THE PATIENT. Dr. G's Story:

A woman was referred to me who had a facial pain that didn't respond to any treatment. One day, after having seen her several times, she told me that she had been sexually abused. Now, I could have just said to her, "these are not orthopedic issues and therefore they have no bearing on my medical treatment. This is not my area. Case closed." I could also have given her drugs or experimental treatments for her facial pain and sent her home. Instead, I try to see the person within the patient. Now in our visits, she talks about sexual abuse, the problems she's had with other physicians, the problems she has continuing with therapy, and other problems she has with her life situation.

Some might say that her issues are all things that do not have a whole lot of bearing on the problem for which she comes to see me or that they do not involve ethics at all. I believe, however, that giving a person the opportunity to

talk about other life issues is important and seems to me to be the ethical approach to treating her illness. Anything short of this would be, to me, an unethical exercise of my powers. Now, after I deal with the musculo-skeletal complaint for which she comes to see me, I talk to her and make suggestions about these life issues. Those may or may not be related to the muscle groups that are causing her symptoms but they are very much related to the way in which the pain effects the way she feels about her life. There is certainly a connection among these factors and her health. When I consider a patient as "a person with a problem" as part of my ethical approach I find that is more satisfying to the patient and more satisfying to me. Over time, I find that this is the essence of being a physician and is at the core of my decision making for my patients.

Participants stated repeatedly that all physician-educators should see the person as well in their medical students, interns, and residents and treat them also with dignity and respect. Dr. C, a cardiologist for 15 years, who is leader in medical education, is a proponent of compassionate healing methods. He stated,

> As an educator, my words and deeds are witnessed by medical students, residents, interns and other health care providers. I must also treat them as people and accord them dignity and respect. To disregard or detach myself from the persons involved, I believe, is to negate the very basis of ethics.

Understanding and Respecting Relationships

All ten participants identified what they considered to be another distinguishing characteristic of the Care Perspective - the emphasis on "meaningful" relationships. In fact, several participants felt that the emphasis on meaningful human relationships is the care perspective's most important feature and critical in medical ethics decision making.

Participants discussed three sets of relationships: (1) the relationship between themselves and their patients; (2) the relationship between their patients and others; and, (3) the relationship between themselves and other health care providers.

Participants observed that all these groups of relationships influence the MedMap. Four used words like bonding to describe the relationship between physician and patient that they associate with the care perspective. Four others repeatedly used words like "deep," "special," "caring," "close," and "unique" to further describe the

relationships. They stated that the relationship had to be meaningful, had to have qualities of trust, honesty, empathy, concern and caring and could not be superficial, casual or accidental. Dr. J's words summed up her thoughts on the care perspective "as reflecting life" when she stated "the care perspective recognizes the importance of relationships. This approach in the MedMap is all about relating to each other and it reflects life."

The Physician-Patient Relationship. Participants said that the physician/patient relationship is central to the MedMap and that the care perspective recognizes that. Dr. I, a general practitioner who worked for five years in Appalachia among the rural poor, is the participant most conversant with the scholarly and theoretical works on the care perspective. She remarked that in her experience "many individuals and relationships are involved today in the multiple layers of decision making regarding a patient's care. At the center, though, is the physician and patient relationship which then radiates out to encompass many others."

Dr. I then described what she considers to be the meaning of the physician/patient relationship in the care perspective. She stated that:

> I think the term "physician/patient relationship" is a medical buzzword. Everyone uses the term in many different ways - including the very impersonal medical "encounter."

However, in the care perspective, the physician/patient relationship has a special meaning - perhaps that of a close partnership. I was taught to concentrate on the first two words, "physician" and "patient" and to think of them as two separate entities: the healer and the diseased. But the care perspective taught me that the emphasis should be on the third word - "relationships." This is a very important area where the care perspective is unique. It teaches the importance of relationships, that is the bonding or the connection between the healer and the sick. The special relationship may come in many forms but it has to be there.

In the next story, the participant, Dr. B who is a general practitioner concerned with women's health issues, built a relationship with his patient that he believed "is essential in medical ethics decision making."

THERE WAS THIS BONDING. Dr. B's Story:

A young woman came in for a pap smear. She had changed her health insurance and hadn't seen a physician for several years. I was gathering background information on her. I don't know exactly what it was I asked her about but the next thing I knew she was in tears. It was the

last thing I expected. So I said, "let's rebook your appointment to take care of the pap test - which is just mechanical stuff. You are obviously very upset, let's talk about what is going on in your life and deal with that today."

My decision to discuss my patient's emotional troubles set my schedule off. But there was this immediate bonding that went on. She is now a regular patient and when she comes in, we have a close interpersonal relationship. It happened very quickly and I can't tell you what it is that I said that made it happen. I think it is my caring for her as a person that made a difference. Sharing a very emotional experience forces me to think about the person within, the person I am trying to heal and care for as a physician. And by my seeing and responding to the person within, this patient comes back for the care she needs and makes it easier for me to treat her medical problem.

Dr. A, a cardiologist with 20 years experience as a physician-educator and one year formally teaching medical ethics, said that the care perspective focuses on recognizing and treating patients as people with whom she and others have a relationship. These relationships she believed are critical to the MedMap. As Dr. A put it, "the

relationships between people form the basis for making medical ethical decisions." In the following story, Dr. A had knowledge of her patient's life and values, and empathy with her circumstances. Without this knowledge and empathy, the patient's decision about foregoing treatment would not have been clinically or ethically acceptable to Dr. A or to the hospital where she practiced.

SUICIDE, SURGERY, OR LETTING NATURE TAKE ITS COURSE. Dr. A's Story:

One of my patients died last week. She was an 81-year-old female with coronary diabetes. A week before she died, she came into the hospital with a cold leg that needed amputation. She then had a small heart attack probably brought on from stress because she did NOT want her leg amputated. She was transferred to the intensive care unit (ICU). From a technical medical treatment perspective, and probably from an ethical approach other than the care perspective, the amputation would have been the "right" decision because it can be a successful therapy and she could continue her life, minus a leg.

We had a long talk about her treatment options. At the end of it she summed up the information I had given her by saying "I basically have three options. I can take too

much insulin which will kill me quickly. I can have the surgery, or I can choose not to have the surgery and let nature take its course."

We then talked about the ethics of these options. Yes, she could "accidentally" overdose herself on her insulin. She agreed, however, that suicide would hurt her family and therefore was not a choice for her. She agreed that letting nature take its course could be unpredictable and lengthy and that dying from progressive organ failure could be very painful. I therefore thought that I had persuaded her that surgery with a prosthesis was not the end of the world.

Then she brought up her fears. She was afraid of surgery - not of the pain - but that it might not go as planned and might leave her "a vegetable" and "attached to machines." We discussed the possibility of "do not resuscitate" (DNR) and she said at her age, she didn't want any of that "resuscitation (CPR) stuff" done; she didn't want "heroics; she wanted to "just go."

Over the weekend she decided against surgery and she began to go downhill with kidney failure and congestive heart failure. She very clearly told everyone she wanted nothing done except to be given pain medications. I spoke with her two

sons long distance and with her daughter about her decision. She had talked to her family and friends about her dying and they accepted her choice. Two days after making her decision she was dead. I can get philosophical and say she gave up and therefore died quickly and maybe that is so. The important thing is that she had a very quiet and peaceful death on her own terms and with the kind of dignity that she wanted.

I, as a physician, had hoped at first, that she would choose surgery. I had been trained to cure at almost any cost, personal or financial, and regardless of the risks. Also my hospital definitely favored all invasive treatments over non-treatment because of fears of subsequent lawsuits. I feared I would face a struggle there. These were some of the pressures influencing me. I really had to stop to think about what my patient wanted and who she was as a person. I had known her for years. She was intelligent, sensitive and fiercely independent. I thought of the risks of surgery for her. Had she had this surgery, she could have been in the hospital now with complications from her diabetes, with congestive heart failure, with possible infection, or with renal failure. She wasn't

being obstinate or difficult, she just wanted to live and to die on her own terms.

Our relationship was very important in our medical ethical decision making. I could accept her decision because I knew so much about her, her life and her values. We trusted each others' judgments, motives, intelligence and principles. I got the hospital to accept her decision of non-treatment, based on my knowledge of her through our long relationship.

Dr. D is a pediatric surgeon in her 50's, with a recent interest in medical ethics who has been teaching at JCAMC for twenty-five years. Her story illustrates the creation of a trusting relationship between physician and patient.

HI. I NEED YOUR CONSENT TO OPERATE. Dr. D's Story:

This Wednesday past, I was called at 4 am. A newborn, hours old, had just been transferred in from a distant hospital. The baby had a life-threatening condition that needed to be corrected immediately. I came in, saw the child, and confirmed the diagnosis. I needed to operate within an hour. There was no parent present. I

called the mother in her hospital bed and we had a 15-minute conversation.

Was this getting informed consent for the surgery or was it building relationships? Ostensibly, the phone call was to get permission to do surgery but you can't just say, "Hi, your child has 'x' condition which means . . . I'm going to operate on your child and I need your consent. Is it okay with you?" Obtaining the informed consent is all that is legally required of me and I think all that is ethically required from me if I were using the traditional ethical approach. But my conscience says "this isn't right, you need to do more before you go ahead and operate." Therefore, I introduced myself, apologized for the fact that we couldn't have a face-to-face discussion and explained what the problem was. I always start with the bottom line. In this case I said to the mother, "you have a child with a problem that is correctable and we are going to come out of this okay." Since inevitably almost every mother of a new-born with a problem will feel guilty, I continued by saying "there is nothing you did in your pregnancy that caused this and nothing you could have done to prevent this." After we went through all the issues, she gave me permission to

operate and said she'd be in as soon as she was discharged from her hospital.

My team, including residents and medical students, completed the surgery in 4 hours and later went to speak with the parents. Their pediatrician, who was someone I knew, had taken the time to copy pages from a textbook on the subject and also gave these parents a drawing describing their child's problem. We were fortunate that the outcome was ideal and the child is doing well now.

The students were quite amazed that I had developed a relationship with the parents so quickly. This relationship would have taken months to develop under other circumstances. Some don't understand the rapport that can develop between parents of a newborn infant and the surgeon who operates on their baby. It is about as deeply intense as you can ever get. Parents will often consult me ten years later, based on the relationship that developed because of the surgery, to say "we're out of state now but before we let another doctor examine our child we wanted to hear what you thought." It is certainly what makes my job fun - knowing I made and still make a difference.

Recognizing and Respecting Their Patients' Relationships with Others. Participants stated that it is important to respect the relationships their patients have with others and felt that the care perspective recognizes the importance of these relationships in the MedMap. Eight of the ten participants said that recognizing the importance of and honoring patients' relationships with others is crucial but time consuming. These relationships are often multiple, complex and intimate in nature. They are familial, religious, ethnic, cultural, and/or medically related in origin. Participants described how they try to develop caring relationships as part of their approach to ethical decisions making with patients and patients' families and with entire communities, recognizing that these relationships fill important needs. Several participants mentioned these relationships as especially important in minority settings.

Dr. J, a general practitioner who has worked for 15 years at an inner city clinic, was a nurse before she became a doctor. She described how she worked hard to develop relationships and to get into the patient's world as follows:

> My practice experience has been running an inner city clinic. In order to develop a trust relationship with these patients I really had to develop an understanding of their culture. Ninety five percent (95%) of my patients were

African Americans. I found them to be medically and educationally underserved, disenfranchised people. There was no way that we could develop a relationship unless I learned to "speak their language" and developed an understanding of where they were coming from. I have also gained an appreciation of their families and how very important they are to the patient and to his/her health and to the decision making.

Dr. C, a male cardiologist, reported,

> I strongly believe I must understand the meaningful relationships in my patients' lives before I can engage in the MedMap for their care. We, in medicine, do tend to think of most interactions as one-on-one. That approach blinds us to the fact that we are dealing with a complex system of relationships. The care ethic in medicine not only sees patients as people but expands to encompass a broad range of relationships.

Dr. H's statements concur with Dr. C's. Dr. H, a general practitioner who has been teaching medical ethics for seven years as well as serving on the hospital ethics committee, insisted that the importance of these multiple relationships "is right there in front of your face." He

said that even if the relationship were limited to one formed between the physician and the patient, the physician must be aware of the existence of (or the lack of) other significant relationships in the patient's life. He states that

> . . . when the care perspective is used, relationships are encouraged, nurtured, fostered and maintained. Through the care perspective I learn about each of my patients as a person, their values, their families, their lives, their relationships with other people who are significant to them, such as a clergy member or even a nurse or therapist involved in their health care. If I didn't use the care perspective, I'm not sure I'd pay much attention to those relationships.

To resolve an ethical impasse for one of his patients, Dr. H indicated that he recognized: (1) the importance of the patient's and family's relationship with their rabbi, and (2) the nursing staff's relationship with the family. He explained that "from this relationship soup an answer appeared."

WE IDENTIFIED THE MISSING LINK. Dr. H's Story:

> I did an ethics consultation in the ICU and I believe I was able to resolve the following

ethical dilemma by approaching this case from the care perspective. The nurses were extremely distressed when family members wanted aggressive treatment continued on their mother. The nurses felt this was medically futile and was causing greater suffering for the patient whom they truly cared about. The 92-year-old patient was comatose. She had heart failure, Alzheimer's disease, and was on artificial nutrition and hydration which meant she had been intubated for "food" and water. The nurses wanted to discontinue the nutrition and hydration tubes. Unbeknownst to the nursing staff, the patient and family members were a tightly bonded Orthodox Jewish family with strong religious beliefs. The nursing staff also did not know that an Orthodox Jewish family turns to their rabbi for recommendations as to what medical treatment should or should not be accepted. To this family, the whole meaning of continuing feeding was very symbolic. In their religion, withholding food from any person is an unethical thing; prolonging life under any circumstances is the right and good thing to do.

Once I identified the relationship with the rabbi as a "missing link" in the treatment process, I was able to help the nursing staff

understand this family's choices. In turn, the nursing staff was able to involve the family's rabbi more closely with the decision making process.

Participants' Relationships with Other Health Care Professionals. Five of the participants observed that physicians do have another group of relationships, beyond those with their patients, that influence the MedMap. These five mentioned a physician's relationships with other health care providers. They went on to describe their own relationship with other physicians, nurses or other health care professionals. Two stated that the value placed on these professional relationships was a unique feature of the care perspective. Dr. I, the participant most familiar with theoretical aspects of the care perspective, stated, "Usually in medicine, the primary relationships are between the physician and the patient. However, from the care perspective, the physician's relationships with other doctors and other health care providers are seen as important in the MedMap."

Drs. A, E, and G noted that individuals in health care systems can interact with one another either in a very stylized and role dependent way as is frequently done, or one can use the care perspective which focuses on the relationships among people. According to Dr. I, the care perspective is an ethical approach which breaks down

traditional role playing - the all-knowing doctor, the brilliant but discounted nurse, the weak, bewildered patient and re-casts people in their true roles, as members and participants in a vibrant complex group of relationships.

Drs. A, E, and G affirm and illustrate the importance of all the people involved in the patient's care in their comments. Dr. A, who is a cardiologist with twenty years experience as a medical educator, stated that

> . . . those of us who approach the MedMap from the care perspective are aware of the importance of relationships and the number of people involved. An amazing array of people are involved in the MedMap along with their personalities, their professional cultures, their families, their previous experiences, and their ethical values. In reality we are all part of very complex relationships within our families, our professions, our cultural groups or the larger society. In every situation the issues come down to the relationships among people.

Participants E and G further addressed the importance of factoring the relationships with other health care professionals into the ethical equation. They described the seriousness of the ethical dilemmas arising among health care professionals themselves. Dr. E, a neurologist

in his 50's, has both practiced medicine and spent many years in research involving human research subjects. He is deeply concerned about ethics and is also a member of the hospital ethics committee. He stated:

> Some of our most vexing ethical dilemmas today are between health care providers. In a given case we may have doctors who do and doctors who do not want to continue treatment; physicians or nurses who consider the same treatment either essential, experimental or medically futile; nurses or other subordinates who do not want to follow orders to continue placing intravenous lines into patients who are hours away from death from highly infectious diseases such as AIDS fearing unnecessary risks to themselves, or nurses or others who are reluctant to intubate patients who are all but legally dead. It has only been very recently that we physicians have considered what our decisions might mean to other health care providers.

Dr. E's story illustrates that caring about other health care professionals is an essential part of the MedMap. His story describes an ethical conflict between several physicians and also between physicians and nurses. It underscores the need to understand the needs and beliefs

of other health care providers who may also have a long and important relationship with the patient.

THEY FIND IT HARD TO CONTINUE. Dr. E's Story:

I was asked to see a patient in the ICU who had cardiac surgery. This was an older patient with preexisting medical problems, who was identified as a known risk before surgery. In the ICU she had additional strokes, with catastrophic damage to the brain. The prognosis for this patient was poor and there was little likelihood of her ever returning to meaningful existence.

This was an all-too-familiar situation. Modern technology has led us to expect a longer life span, yet death is inevitable at some point. In this case the risks of surgery were very high, with many complicating conditions and there had been no discussions beforehand with the patient or family about "what if." As part of the ethical process we should have discussed this with the patient and family prior to surgery. Now we could not.

We were faced with a numbing decision. Should we go all out to keep her in the present condition or should we withdraw all respiratory support, withdraw all medications to control her

heart rhythm and give her a "no code" [i.e., do not resuscitate] status? We knew that any decision not to pursue aggressive, invasive and/or heroic actions would hasten her death.

The many different views and values among the health care providers who were treating this patient led to an ethical impasse. There were differences between doctor and doctor, doctor and nurses, and doctors, nurses and family. The surgeon wanted to continue all treatments. Some nurses wanted all treatments discontinued, others wanted only certain ones discontinued. The family was ambivalent. I, as consultant, felt all treatments should be discontinued.

The surgeon felt responsible for the outcome of the surgery which he had performed. He was reluctant to limit treatment and have the patient "die." Perhaps he considered her death would be a reflection on his skill. The family who helped make the decision to go ahead with the surgery - no matter what the risks, may have felt some responsibility, perhaps some guilt, about the way things turned out. They were upset, unhappy and grieving. They did not seem to want to make any more decisions. The nursing staff, who are all-too-accustomed to this scenario, were finding it hard to continue to treat, that is, to physically

touch, and treat and care for what was an essentially dead body. While I thought it would have been ethically appropriate to withdraw treatment the first day I saw this patient, it took time for all those involved to get comfortable. It took them five days to finally decide to withdraw life supports and to provide no other interventions. The patient, of course, died immediately. During those five days, I convened the Ethics Committee and invited the family and health care providers. We attempted to clarify the issues and understand each other's viewpoints. This whole process was helpful in building better relationships among the health care providers.

Dr. G, an orthopedic surgeon, also illustrated this care consideration that involved caring about the other health care professionals as part of the ethical decision making process in an end of life decision with the following story.

OUR MUTUAL SOLUTION. Dr. G's Story:

I had a young patient who had broken his back in an accident and who then had a severe stroke. The nursing staff wanted to terminate life support before I was ready to. The nurses

and I discussed our reasons and eventually we began to hear each other. Then we jointly discussed the issues with the family. We finally reached a solution acceptable to us all. Our mutual solution was to continue life support measures to give the family a day or two to adjust and to accept the reality of the situation. Resolving this ethical conflict took time. It took time to hear everyone's concerns and to attend to them. I was able to build the trust of all who were involved, by caring enough to listen to their concerns and by trying to find some middle ground we all could be happy with.

Six of the ten participants discussed their personal attempts to build, develop, and maintain a "bonding" relationship with different people in their professional lives: with patients and patients' families; with students and with other health care providers. Participants also mentioned their own relationships with their families. This is separately discussed in Chapter 5.

Many believed that good relationships lessened the number and severity of ethical issues and dilemmas. One participant, Dr. G, believes the care perspective, specifically, the building and maintaining of meaningful relationships, could be used in preventing or defusing ethical dilemmas. He stated,

I believe that if I, as a physician, have a good relationship with someone, there is little chance of a situation reaching an ethical impasse. I regard difference in values, not as ethical dilemmas, not as problems, but as a call for an alterative approach to the MedMap - one where I try to build relationships to prevent or solve treatment issues. Once treatment issues are talked over and differences are shared, a solution usually becomes apparent. I think the same about malpractice; if I have a good relationship with a patient s/he is less likely to sue me. Building a relationship can be very time consuming but I feel it is definitely worth it.

Learning the Context of the Patient's Life

All ten participants identified a third distinguishing characteristic of the care perspective. The care perspective, they stated, includes an empathic response to the context of the person's life: that is, the person's situation, values, limitations and choices. Participants said that knowing the context, i.e., the fabric of the patients' lives, helped them decide how to approach treatment issues and ethical dilemmas. According to Dr. E, "I need to understand the details of my patient's life so that I can understand my patient's medical needs better.

It is 'getting into the patient's head' so that I can make an informed choice about his/her treatment."

Several of the participants mentioned that knowledge about the patient's circumstances was important but that mere knowledge was not enough. They used the word "empathy" to further describe what they were trying to convey. For example, Dr. J stated that

> Empathy is really the cornerstone of medical ethics for me. I define empathy as being responsive and sensitive to the person's life; and as sharing emotions or experiences. For me, this means "getting into" the real person behind the illness and sharing his/her emotion over it. I certainly can't change places with a person but I can really try to the greatest extent that I can, to understand and feel how that patient is seeing and feeling the world.

Dr. D, a pediatric surgeon who has been a medical educator for 25 years, described both her values and how she reached an empathetic understanding of a family's belief system, their sensitivities, and their culture in the process that underscores the third distinguishing characteristic.

DEALING WITH A COURT ORDER FOR TREATMENT. Dr. D's Story:

A few years ago, a baby with many serious medical conditions was transferred to my hospital for emergency surgery. The baby's parents were Amish. The parents did not want surgery. The hospital did - probably due to a federal law about treating handicapped neonates. Therefore the hospital obtained a court order to operate. Although the court ordered surgery, I was reluctant to go against the parents' wishes. I wanted to work with the parents. I spent many hours explaining the procedure, and possible positive outcomes, trying to convince them that I should operate. They finally, but reluctantly, agreed to the surgery even though they stated they did not believe the child would live. If I had not been able to persuade them, I, ethically, could not have operated against their wishes, despite the court order. I would have referred them to another doctor.

Part way through the surgery, I realized there were additional complications which could not be corrected. The child died. The parents were very comforting to me and said that they knew all along that the surgery would not be successful. They said that they also knew I had

to fulfill my own sense of moral duty as a surgeon and that was why they had given me their permission to operate. Although I could not save the baby's life, the parents were calm, gracious and not angry. We were all very sad.

As a parent I empathized with them. As a person with my own deep religious convictions, I empathized with them. As a physician who sometimes has reservations about interference from the legal system, I sympathized with them. And they in turn empathized with me, as a surgeon with a duty to perform.

The next two stories by Drs. B and J who are both family practitioners, demonstrate that as part of the MedMap, physicians must know something about the life circumstances of their patients. These stories illustrate the theme of paying attention to the context or details of patients lives and to the values of their patients.

SHE WOULD NOT AGREE. Dr. B's Story:

One of my patients nearly did not get the care that she needed because of an ethical impasse. She was a 20-year-old woman with cancer who needed chemotherapy. The cancer specialists were concerned about her becoming pregnant because she was sexually active with her spouse.

They believed that she must have chemotherapy, but because it can be very mutagenic, she also had to agree to use birth control. She refused to use birth control. She also refused to have an abortion if she got pregnant. Since she would not agree to use birth control measures or to have an abortion, the cancer specialists refused to give her chemotherapy at their clinic. However, the cancer specialists were distressed with her refusal and called me since she was my patient. They asked me to "convince" her to use birth control. I said "I'll certainly have a discussion with her but it is her decision and I'm not going to insist that she use birth control as long as she understands and accepts the consequences." However, I knew that ethically I would have to do a lot more than just invoke the principle of autonomy in this ethical dilemma.

I sat down with Chris and explored with her what things were important to her. I needed to know why she felt this way about birth control, and whether she really understood that her survival was at stake here. She explained that she was a deeply religious woman. Her mother had died shortly after she was born; her father died of cancer when she was 10; and her only brother

had been killed in the Vietnam War. She was raised by a variety of family members and friends. Her church had become her family and her support system. The church had given her values and her life meaning. It also forbade abortions and birth control. She could not violate its principles even if it meant sacrificing her own life. Although I did not share her values, or quite frankly understand them, I could respect how her life experiences had formed her.

She convinced me that she understood what she was doing and presented herself as responsible enough not to get pregnant during this three month period of chemotherapy. After a long discussion, first with her, about her health, her life experiences and the underpinnings of her beliefs, and then with the cancer specialists, we were mutually satisfied that we had reached an ethically sound decision. She would receive chemotherapy and she would be responsible about not getting pregnant. I think this shows how absolutely crucial it is to find out what the patient may value, need or want in his/her life.

There are other situations where an understanding of the context of a person's life is critical to the Medmap. In the next example, another participant illustrates again the notion that context, or where the patient is coming from literally and figuratively, is critical to a physician's decision making process. One such was told by Dr. J.

FIVE BUSES, THREE KIDS AND NO MONEY. Dr. J's Story:

One of our clinic patients is a 32-year-old woman who is HIV positive. She was often late, failed to keep appointments, and failed to take the prescribed medicine to slow the inevitable onset of AIDS. Her behavior was very annoying to the medical team and we were tempted to dismiss her by saying "It's her decision. She is an adult and can make her own decisions. If she doesn't want medical care that is her business and we respect her autonomy." However, deep down, that didn't seem ethical to me. So we decided to look beyond her disease and to learn more about her life. The data was all there but it was scattered throughout her records. No one had paid any real attention to it or what it meant. We learned that she is a single parent, with three pre-school age children and she lives

on welfare in a rural area 25 miles away. There is very limited public transportation and to get here to the clinic she has to take five separate buses each way with waits in between. She also has to either bring her children with her or arrange for a sitter. She usually has no money for a sitter or for her very expensive medicine. You can imagine how I felt after reading these facts. Although at our clinic she had been seeing many physicians and other health care workers during each visit, none of us had really heard what she said or thought about her circumstances. We belatedly took these things into account and we were then able to arrange for her to get her tests and medications at her local community hospital.

Is this an example of medical ethics? Yes, I think it is. It was our understanding of the context of this woman's life and her very serious illness that influenced our medical ethical decision making about her care.

Summary of Participants' Views of Fundamental Characteristics of the Care Perspective in the MedMap

Participants identified what they considered to be the distinguishing characteristics that they commonly connected with the care perspective. These characteristics were mentioned by at least eight of the ten participants, my

criteria for commonality. The first characteristic was considering the person within every patient. The second characteristic was considering and respecting relationships. The third was considering the context of the patient's life experiences. These three characteristics were prevalent throughout the participants' commentaries and stories during both interview sessions. One participant, Dr. G called the characteristics "care considerations."

There were several other characteristics identified. Because one to three participants, but not all, mentioned these I did not treat them in depth. These characteristics included: trust, universality, "it is concrete," and "it is the "holistic approach" to medical ethics."

While all participants discussed relationships as a distinguishing characteristic of the care perspective, they also gave examples of relationships that they did not associate with it. Regarding patients, these ranged from: parental, protective, therapeutic, to patient as supplicant and physician as god-like; in describing relationships with other physicians they ranged from "locker room" relationship, team players, to collegial and collaborative; relationships with students ranged from apprentice/master to teacher/mentor.

C H A P T E R 5

EXPERIENCES WITH THE CARE PERSPECTIVE

Participants discussed at length their experiences with the care perspective. Each of the ten participants viewed his/her medical ethical decision making as having evolved to a point where it now included both understanding and application of the care perspective. Participants talked about their own educational experiences and initial ethical approach, their change in approach, the factors that influenced the change, and their new ethical approaches using the care perspective. Several of them indicated that their approach to the MedMap is still evolving.

In addition to describing the evolution of their approach to the MedMap, participants talked about the care perspective as giving meaning to their professional experiences and as caring for themselves by setting limits.

Past Educational Experiences and Initial Ethical Approach

All participants referenced the changes in medicine as the impetus behind the changes in their own ethical decision making. All noted that dramatic technological changes in medicine over the past 30 years have challenged the definitions of life, death and quality of life. Dr. E said,

In response to all these changes, medical ethics has been evolving rapidly also over these past thirty years. Questions of "can we" are being transformed into ethical questions of "should we"? At one time there were no questions [about using the most advanced technologies] - if it could be done [through heroic measures] - or if we believed it could, we just did it. Now things are not so clear cut. We are doctors, not ethicists. We do have to make very important decisions, sometimes immediately, but most of us have little or no training in ethics. Even if we did, we hardly ever have the luxury of time to think about theories. Theories are all well and good but we, doctors, have to resolve issues, put theories into practice and then live with our decisions.

Participants all described their early medical education as including little or no formal training in ethics or the care perspective. In fact, 9 of the 10 participants reported that (1) formal ethics were omitted from their own education; (2) feelings of compassion were discouraged in their education and training; and (3) relationships between physician and patient and between physician and student were formal, distant and hierarchical.

Dr. A stated,

> Twenty years ago, there were no discussions about ethics in medical school. It just wasn't done. We focused just on the science of medicine not on ethics and certainly not on caring relationships with patients or among health care professionals. The focus was on the diseased organ and seeing the body as a human machine. There was little thought given to the context of the patient's life situation. There was no discussion about what you as a caregiver might feel regarding a patient. In fact, it was considered inappropriate to discuss these types of issues then.

Dr. C reported a similar experience: I must characterize my educational experiences as a medical student twenty years ago, as unsatisfactory and not in any way nourishing or nurturing. Classwork was very formal. We were subjected to questioning by faculty members regarding "scientific facts" in a manner that sometimes was frightening and that very often was humiliating. We had virtually no formal or informal discussion of ethical issues.

Dr. J stated:

> My relationship with the faculty when I was a student really wasn't a relationship as I think

of one. I was at a very large medical school where I was basically a number. You studied. The things the care perspective focuses on such as relationships, context, connection, caring, just were not there for students or for patients. That's sad but true.

Dr. A reported:

As a woman, I was a minority. Unlike today, when I would be more apt to celebrate this fact, I wanted to just fit in and be like the male medical students. There was a feeling among the women students, fostered by the system, that we must not be too caring, too emotional, or become too involved with our patients. I think a level of personalized caring comes naturally to us as women but I certainly felt, and the other women felt, that we had to avoid feeling, avoid too much caring, avoid too much passion or compassion, when we were on rounds with our attendings and with the other residents. It was made clear to us that the stereotype of a woman doctor was of a "touchy feely" person who was not technically sound. We were trying to avoid that stereotype. We wanted to be exactly like male physicians.

All of the participants went beyond mere descriptions of their education and early practice. They gave explanations for why they thought that ethics training was not included in their medical education. Drs. B, I and E's explanations for the lack of ethics training in general, and in caring and compassion in particular, relate to factors in the training of physicians.

Dr. B, a family practice physician explained:

> I believe the factor with the most impact, was the exhilarating and the unquestioning belief that science, with its objectivity, had all the answers. This was coupled with the amazing new technologies that gave us a sense of tremendous power over diseases. I think we developed an attitude about medicine and ourselves. It was based on the belief that we had privileged information. That attitude framed my educational experience. We were scientific miracle workers working our scientific miracles on the human form. We thought scientific knowledge based on quantifiable data was what counted. It was the only thing that had value and we possessed this valuable knowledge. I was trained to think that anything that was not quantifiable was almost valueless. We thought we were above questioning by anyone except our peers, if even then. We didn't need ethics. Science determined what was

right or wrong. Of course, to this day, I adhere to the scientific way of thinking about medical data, but I now believe that there are valid modes of thought that do not fit into the scientific framework. Ethics is a subject that is not really quantifiable, and the care perspective is even less so.

Dr. E, a neurologist, described another factor in the training of physicians as the hierarchy in medical education and practice. He said:

> There is this very traditional autocratic flavor in medical school. Those considered to have the most experience in medical knowledge are exalted. This attitude is most striking among residents. There was and is a cascade of seniority. Of course, the attending (senior faculty) walks on water. The senior resident lords it over the junior who lords it over the intern who lords it over the medical student. The attitude toward ethics seemed to be: Why are you questioning me? I, as the most senior person present at a given time, have the most scientific knowledge and am the most experienced, and I have to be right.

We were also trained to distance ourself from the patient and from the real meaning of the

diagnosis to the patient. We often speak in "doctorese" to make the situation less personal and less emotionally charged for us as well as for the patient. The standard was and is "disinterested concern."

Dr. I, a family practice physician, described a third factor in the training of physicians. She said:

> The hospital is the setting for medical education. We see patients in the artificial circumstance of being in a hospital and we only see a tiny slice of this person's life as a human being. Most patients who come to a University Hospital, like ours, are very sick. Patients with unusual complications and multiple problems are often referred to the specialists here. This reinforces the emphasis on the disease. Furthermore, most of us have no prior relationship with these patients and once we cure them, we do not see them again. So the educational setting itself is really a factor that works against the care perspective.

Dr. H, a general practitioner, said:

> There is a dilemma in medical education. The way we teach our students hasn't changed so much. Students and residents are still trained

basically to value scientific facts, scientific methods, scientific objectivity and quantifiable data. It is not a matter of saying that the patient isn't important. It is a matter of being overwhelmed and awed by all of the scientific facts and the technology that we have had the last twenty years and sort of forgetting the patient in the process.

How Participants have Changed Their Approach

All participants reported that they had changed from rarely, if ever, thinking about ethics to thinking about ethical approaches often. Moreover, seven of the ten participants reported that they have also developed an awareness of the importance of the characteristics or considerations they identify with the care perspective. Dr. I, offered an explanation. She states,

> . . . the care perspective, once accepted, pervades all interactions and all decisions. The care perspective is important in the moral development of all individuals. It helps me define how I am going to relate to others. If you believe in it as a concept it surges through all aspects of your life. If the care perspective were taught in medical education, physicians would learn to consider the patient as a person in the context of a network of

relationships, in the context of his/her own personal values and beliefs and in the context of what s/he considers a quality of life. It would make a physician's life much easier to learn this at the beginning of his/her career.

Other participants described the changes in their own approach. Dr. G stated:

> I learned something from making medical ethical decisions that I really didn't get in training. I learned that I am not just caring for a patient. The care perspective also allows me to see the illness in the context of the person's whole life, instead of seeing only the illness or the disease. I think I am a much better practitioner because of this. In fact, I have changed the dynamic between myself and the patient or the student in almost every situation. My compulsive nature coupled with my training make me go through all the medical questions and obtain all the medical information about the disease for which the patient is seeing me. Now in addition I ask each patient about him/herself and ask if there is anything else in his/her life s/he wants to talk about. I have gradually come to realize that health issues usually involve the patient's whole life as well as the patient's

"family." By family, I mean whoever the patient considers as his/her family: anyone with whom the patient is closely and emotionally connected. Even though this takes a lot of my time it may in fact benefit both me and the patient when I make the time to talk to the family about their issues. I think that this is very important and that this is caring. This is what being a doctor is all about. Machines and medicines alone can not do this.

Factors that Influenced the Change

Nine participants intentionally use the care perspective in their present ethical thinking. They reported two factors that have influenced the change in their approach to the MedMap. The first factor was that their own concept of ethics has changed over time.

Some of the explanations given for this change included: learning that ethics is not exclusively about "media attention grabbing" issues" said one; another said, "ethics is not restricted to a classroom"; and still another said "ethics includes all aspects of how one person treats another human being." Several recognized that simple daily interactions as well as the successful resolution of complex life and death issues involve ethics and require understanding the importance of relationships. Dr. A, observed that at one time she had considered ethics

and ethical issues to be "neon issues." She had thought ethical issues were not about ordinary daily concerns but instead were so far removed from her clinical practice that they were entirely irrelevant to her.

Several other participants also reported that they used to believe that ethics only existed around extreme cases that involved very ill people with diseases such as AIDS, or around DNR (do not resuscitate) and other end of life issues for the terminally ill. For example, Dr. J, who is a general practitioner, with 15 years experience as a physician-educator in an inner city clinic, described how her concept of ethics has been changing and expanding.

MEGA ISSUES. Dr. J's Comments:

Most doctors and even some ethicists I know, seem to think that medical ethics is about the huge issues. You know, the crisis kinds of decisions that get media play, such as "end of life decisions": do we unplug the machines? is the person dead yet? do we harvest the salvageable organs? do we keep a brain-dead woman, pregnant with a ten week fetus, going on life support machines so that the fetus may develop, perhaps abnormally? I'm learning that there are ethical concerns about simple everyday, operational things and not just the media issues. In fact, I believe that it is because we have

divorced ethics from the everyday "stuff" and because we somehow think ethics can not be taught that we end up with these crises situations in the first place.

Too many times we think that there has to be an ethical dilemma for there to be an ethics issue. I now feel that every interaction I have has an ethical component. The ethical part is very simple. It is how I relate to my patient and how I treat the non-medical part of my patient's life. In fact I believe that most decisions in the MedMap are not grand crisis decisions; instead they are based on my knowing who my patient is. It is true that the care perspective lacks the pizazz or "sexiness" of crisis ethical decision making. It sometimes seems so simple but it is really very profound. I think it is also fundamental to what we as doctors are trying to be.

Participants noted a second factor that changed their approach to the MedMap. They began learning about the care perspective at the same time that they were beginning to change their focus from the diseased organ to a person within the context of a life. They became aware of certain features of the care perspective which they now consider essential in the MedMap.

Participants reported that they had changed the focus of their attention from the illness or diseased organ to the person within the context of a whole life beyond the illness. In describing this change, Dr. I stated:

> . . . as I began to have confidence in my own decision making, I began to focus on what I thought was "important" in the MedMap. I was also keeping up with medical ethics theories including those in the nursing literature. I was delighted to discover that there was a theory that really seemed to fit with what I believed in. It made sense. Personhood, context, relationships. It all fit what I felt I and my patients needed for MedMap.

Dr. C who is a leading medical educator who also serves on the hospital ethics committee described this change,

> More and more emphasis in medicine is on treating the whole person, not just the illness. I have grown aware of the importance of relationships and how building relationships is a valuable part of my medical and ethical approach. As I began to develop deeper relationships with my patients, I could sense they had more trust in my competence even though it wasn't my competence that had changed at all. The change was that I

> treated my patients as living, thinking, caring adults in important relationships with others and with me and not as an illness or group of diagnoses.

New Approaches

The participants reported that as part of their evolutionary development toward the care perspective, they have taken new but simple approaches. The participants reported that they ultimately recognized that it is the daily actions that are addressed by the care considerations that have important and sometimes even profound significance for them. Several described their new approach as "just doing lots of little things." Dr. A states,

> There are a lot of simple things that you can do for your patients to show them you truly understand they are suffering and that you care. As a cardiologist, I touch patients. It is easy for me to take a pulse. I also feel it is important to be on eye level. I pull up a chair; I ask permission to sit on the bed. I give the sense that I'm here for you, the patient, that I am not in a rush. I'm going to spend some time with you. Even though this particular patient may be the first of forty patients I must see that day, it is imperative that I recognize that

she is a unique person who is facing this illness, complication, etc., basically for the first time, even though it may be my 1,500th angioplasty in a year.

Dr. J describes her new approach as building what she calls real relationships:

> I have to get into my patients' lives and to me that means building a real relationship with my patient. I do not want an office visit to be merely the encounter between an all-knowing doctor and a sick, passive patient, but a relationship that recognizes two human beings: one who is a doctor and may be able to help, and one who is sick and needs help. I realized that if I care about a person I care about where they are coming from, who they are, their environment, their life. I ask questions and think about the implications. What is your living situation? Who is there to help you? How do you get here? Did you have problems getting here? These questions are not for the sake of obtaining demographic data but for the sake of understanding the life circumstances of the patient.

According to Dr. H, who is a general practitioner,

> I bring a better informed, more mature and thoughtful approach to disease and illness and I try many different things now. I make tailored treatment plans to fit an individual's medical needs. I have begun to do the same in ethics too. I used to only teach the justice perspective. I instructed students in the four principles that were taken as the basis of ethical decision making. But more and more I'm asking myself why only one theory; why only four principles? I read about the care perspective and it seemed to capture something new and different - a different way of looking at issues, a different approach to solving ethical dilemmas that seemed to fit with what I actually do in my practice. To me the care perspective meets the difficult, often highly complex ethical issues we face here. So I am adding this approach when I teach my students.

Drs. J, F, I and H each describe developing a different and deeper understanding of the significance of caring about a person, about context and relationships and how this deeper understanding led to changes in their ways of looking at issues and their new approaches to decision

making. Dr. J, a family practice physician, describes her new ethical approach with her students as follows:

I WOULD NEVER HAVE KNOWN. Dr. J's Story:

A student had been assigned to me. As her advisor, I asked questions about her coursework in medical school. She paid no attention. She wasn't interested in what I was trying to talk to her about. I found myself wondering about her and wondering how such a person ever got into medical school and what kind of doctor she would make. I was very concerned about her attitude toward her studies. Was she trying to fail? Wanting to fail? Was she just wasting my time? Then I started asking questions that were not related to her classwork, such as, "Are you ok? You don't seem comfortable. What is going on? Is there something I can do?" She opened up a floodgate and talked about troublesome issues and problems in her past, which were resurrected when she started medical school and that were paralyzing her performance.

It was a huge learning experience for me. I realized how far I had come. Early in my career, that student would never have told me about her problems. I would have seen her as an advisee only one or two times during her entire four

years. She would have had her required meeting with me, as her advisor, then she would have left and I would never have known. I now feel that I have a receptivity and sensitivity that picks up on the subtle clues I receive from patients and students that are so very important in ethical decision making.

Dr. F, a neurologist, described her new approach as evolving from one of detached objectivity toward one that contained characteristics of the care perspective.

I WOULD HAVE MISSED THE WHOLE THING. Dr. F's story:

I had a male patient who was very uncomfortable and rather difficult. I didn't seem to be able to talk to him at all. He was very gruff; he wouldn't look me in the eye; he wasn't answering my questions. To myself, I said "Stop. Something is going on here." To him, I said "I notice that you are a little uncomfortable. Is there some way I can help you?" With this, the patient told me he needed to see a male doctor. The patient had come in with "x" and he really didn't want me to know about it or to treat it. I would have missed that whole thing if I hadn't been sensitive to

the tension between us, aware that he was not making eye contact, aware that he was not really answering my questions. I think a lot of my colleagues fault the patient in this kind of encounter. They assume this behavior is rejection and take it personally and think "What is this? This guy is wasting my time. I don't want to bother with him." But I don't. I pay close attention to my patient to ensure that he/she, as a person, is comfortable with me as a doctor and person. The care perspective allowed me to care enough about this patient to find out what he needed.

Dr. H, a general practitioner who is on the ethics committee, described his changed way of looking at issues and the new approach he took in medical ethics. He stated:

> I used to be a dictatorial, arrogant rascal. I never took time for my patients, rarely saw their families, and often felt annoyance at the intrusion of their questions. I can't believe I once felt that way. But I did. I think now it was beastly. But then I thought I was giving my patients first-rate scientific care. Now I make a point of building a real relationship with the patient, talking with the family, and recognizing the importance of these relationships in any

decision making. This takes time. These discussions with the patient and family help me understand more about my patient's illness and whether I can count on the family in follow-up care. It may help when it comes time to make decisions like DNR. I believe it even helps to prevent lawsuits and legal battles, too. It takes a lot of time to talk this deeply with patients and with their families but now I do it because I know it is the right thing to do.

Dr. I described her new approach to medical ethics, and attributed it in part to her growing familiarity with the care perspective.

AS IF THEY DO NOT COUNT. Dr. I's Comments:

It happened slowly but with more experiences I began to think a lot about relationships and I began to notice the way people who were not physicians or faculty were treated around here. Nurses, lab techs, ward clerks, and secretaries were not being treated the way they should be. I would see a lot of physicians treating staff people without care and without respect as if they do not count. It felt wrong to me. I would call it unethical. Am I qualified to label it as such? Perhaps not. But to me it is unethical

and I want to change it. I am not the only one who sees this mistreatment of others and considers it wrong. Patients see it; more importantly, medical students see it and residents see it. Future physicians are seeing practicing physicians treating staff people as if they do not count. This uncaring behavior becomes part of my overall ethical concern. Ethical treatment of others becomes part of who you are and part of your every day life - at least if you are a physician and take your profession seriously. We need to concern ourselves with the ethical treatment of all people, whether they be patients, families, students, staff, or all other health care providers.

Still Evolving

Five participants view their movement toward the care perspective as still evolving. They described a deepening understanding of medical ethics in general and the care perspective in particular. Dr. C, a cardiologist and member of the ethics committee, reported that his interest in ethics, his interest in understanding the importance of human relationships and his ability to establish relationships has evolved pretty much in line with societal changes and continues to grow.

ALL OF THAT HAS CHANGED. Dr. C's Comments:

I think a lot about ethics now and expect that my thinking and knowledge will keep changing and evolving. I am open to changes and don't wish to fight or stymie them. When I first started out, physicians were in much more hierarchical, more formal positions; perhaps because physicians acted that way and also because society expected it of us. For me, all of that has changed. My experience with patients has been changing pretty much in line with societal changes. There has been a slow transformation from "playing the role of disinterested concern" which was the standard when I was being trained to one that is much more mutually nurturing. As society changed and became more open and accepting, less formal and rigid, my patients changed and I have changed.

Now I feel much more comfortable, expressing some of my own values and feelings and I no longer feel that I have to play the role of the disinterested, patronizing physician who has all the answers. I feel and enjoy a warmth that comes along with this new kind of relationship. It enriches my physician/patient experience.

Four other participants had similar thoughts. Several of these participants also reported that between the two interview sessions they had with the researcher, they had new insights regarding medical ethics. The interview process seemed to open up new questions and understandings for them. For example, Dr. J said,

> When I was thinking about and describing the care perspective (to you as part of your study) I became aware that I glossed over staff treatment as an ethical issue. I hadn't really thought about staff in any great depth before. I'm not sure I will overlook them again.

Adding Meaning to Professional Life

In addition to describing how their approach to the MedMap has evolved to include the care perspective, participants described the care perspective as giving meaning to their professional lives. Participants framed and evaluated many of their experiences by telling about a certain type of relationship that they built, developed or maintained with their patients, their students and others. All participants report that although they derive great satisfaction from accurate diagnosis, and successful treatment, it is the connectedness, the bonding, with patients and/or their families, with medical students and residents, that they, as physicians, remember, strive for and use as a basis of medical ethics decision-making.

Participants described experiences of bonding and stated that it gives meaning to them and guides them toward doing the right thing for their patients. They also described a sense of moral satisfaction that they felt came from doing the right thing.

Dr. A who is a cardiologist said:

> I consider the special personal interaction with my patients as one of the most important parts of medical ethics and I believe it is also the best part of medicine. It vitalizes me. In most cases, we doctors don't cure anyone, we make patients feel better and we stabilize them. We may think what we are doing is "upping this" dosage or "lowering that" or resolving a particular ethical question. Certainly our knowledge, our treatments, our medicines are very important, but there is just so much more that enters into the treatment of a fellow human being through a caring physician/patient relationship. But we don't know that from our medical training. With years of experience I have grown to realize that a large part of my treatment is my relationship with patients.

Dr. B who is a family practice doctor reported in much the same terms. He said,

A lot of the richness and satisfaction of my medical practice comes from the connection or bonding that I feel with my patients. I admit it feels good to make a great diagnosis or know the answer on rounds. But it is the relationships that are so important in my decision making, which give me the moral satisfaction that I am doing the right thing for this person. It feels so good to walk into a patient's room and sense this connectedness. To me this means my doctor cares about me and my problem and will make sure the "right" decisions (that is "correct" medically and "good" or "right" ethically) will be made. With patients that I've built a relationship I can sense this trust and connectedness. It's a nice feeling. It's real satisfaction. There is that feeling of caring, of connection, of bonding, of helping, of doing the right thing. It's a wonderful thing.

Dr. H, a general practitioner serving on the ethics committee, expressed a similar view:

> I am always proud of my technical ability to make the correct diagnosis but it is the feeling of connection, of bonding, of meaningful relationships with my patients or students that are most important to me. These are the

experiences that give meaning to me as a doctor and as a teacher. These are what I think about first and am aware of most when I'm faced with an ethical decision.

Dr. C, a cardiologist serving on the ethics committee, reports that he believes bonding is part of the ethical response to any patient. He states:

> . . . having a deep, significant relationship gives a sense of comfort to your patient and the patients' family during times of illness and decision making. There is nothing worse than the isolating effect of an illness. The care perspective with its emphasis on relationships can dispel some of the isolation. You can make yourself available to the patient in a way that they feel you are there with them, virtually suffering emotionally with them. Patients in turn give back to you. Let's face it we all want to feel as if we are doing the right thing. Even if you are not able to keep the patient alive or even to restore the patient to health you can provide comfort and a sense that you are co-travelers with the patient. All patients and their families usually respond very favorably to this caring approach. When my patients are pleased by my care I am gratified and I say to myself this is why I continue to be a doctor. I

have never had a patient complain "you care too much, you try too hard, or you are too available for my questions."

Dr. E's story echoes Dr. C's comments. Dr. E, a neurologist who is on the ethics committee, illustrates his belief that a strong caring relationship is the right or ethical approach to respond to any patient.

A WARM GLOW. Dr. E's Story:

A 35-year-old woman, diagnosed with multiple sclerosis six years ago, was given a very poor prognosis. She had been so upset by the way a physician had told her about her illness that she stayed away from doctors ever since. She had some new symptoms and had recently heard of some new therapeutic options described in the press so reluctantly she came to me on the recommendation of a friend.

We sat down and talked about <u>her</u>, about how the disease had affected her, about the disease in general and about some approaches to the management of her disease. We talked about more than the medical part of the disease - a disease that is very unpredictable. We talked about her history, the problems that she had had, the effect her illness has had on her life, on her

family, and we theorized what could happen in the future.

It was very clear to me that this was the first time that any physician had sat down with her and talked about her, and about how the disease affected her. At the end of the 1 1/2 hour visit we both walked out of the room with a warm glow. I remember thinking, "Gee, something nice happened here. This is a relationship we can build on." I went home believing, that despite my time pressures and pressures from the clinic to see more patients more quickly, I had done the right thing at the right time and I confess I felt really good about my own soul.

Seven of the ten participants mentioned as well the importance of bonding with their medical students and residents. Dr. B described his experience when he was a student with faculty from the Department of Family Medicine.

> These people were much more interested in me than faculty physicians from other departments within the medical center. They were interested in me as a person. They knew who I was. They had an idea of my background, what my interests were, and that I had a family. This had great meaning for me and in fact was the deciding

factor in my career choice to become a family practice doctor.

Bonding relationships with other health care providers were mentioned least often (in fact, by only two participants) and appeared to be overlooked, forgotten or of less importance than the others.

Caring for Oneself within the Care Perspective

In addition to describing the care perspective as adding meaning to their professional lives, participants also described the care perspective as encouraging them to care for themselves as part of the ethical equation. Participants describe how through their experiences they learned that taking care of oneself is a legitimate, desirable and ethical form of caring and important in the MedMap. They believe that caring for oneself is consistent with the care perspective.

The notion of caring for oneself as well as for others emerged slowly but invariably - often in terms of setting limits to the demands from overly needy, overly dependent, overly friendly patients, medical students or others. Each participant independently mentioned that caring about others invariably required caring for oneself and one's own personal relationships. The frequency and intensity of this response suggested that participants had thought about this issue repeatedly. They indicated that by caring for

themselves as well as others, their sense of the connectedness between themselves and others deepened.

All participants stated that they viewed themselves 1) as caring professionals deeply committed to others, and 2) as individuals who needed to care for themselves. To be both, they set boundaries for their relationships with their patients, students, staff and family. Although some of the language they used seemed to the researcher to reflect current idioms and even current fads in self-awareness, it was clear that all participants grappled with balancing their professional and personal life as part of their ethical decision making.

One of the criticisms in the literature of the care perspective is that one runs the risk of becoming overly attached, overly involved in others' lives and neglectful of one's own needs. One participant felt that this was an unwarranted criticism that springs from misinterpretations of the care perspective. Several other participants felt this as a valid concern that they were addressing as part of an ongoing process.

Each felt that ethical treatment included treating him/herself properly. Proper treatment included knowing when to say yes and when to say no, how to clarify expectations within the relationships and how to limit time and attention in a caring manner. Although relationships are key to the care perspective, participants note that limits must be placed on the demands of certain patients

and certain students. They described how given these demands they had to learn to care for themselves as individuals, as physicians, as people with families of their own. The following four representative stories illustrate this point about setting limits to caring as part of the MedMap - beginning with Dr. J, a family practice physician with a demanding inner city practice.

CALL ME IF YOU NEED ME. Dr. J's Story:

I used to ignore taking care of myself and my needs. To me that was equivalent to selfishness. I believed it was morally right to care completely for others - to take care of the sick, and the young, and the old, and those less fortunate than myself. I still believe that caring about a student or a patient as a person is fundamental to what I do as a physician and is a fundamental principle of right treatment. However, caring doesn't mean losing yourself in a patient or student either. This is a problem that I and many others struggle with.

When I first started working, I let my work interfere with my family life. I would come home and call some patients to be sure they were okay. I'd give others my home phone number. My husband, also a physician, got very upset. He was feeling that we had no time for each other.

He would come home and I would be on the phone with my patients. This was taking a toll on my marriage, my family and me. I eventually realized that this practice was not right for my patients or good for me. I was being more caring to other people than to myself or my family and I began to set limits and I let my patients know them in a straightforward, gentle and caring way.

Now I feel like I'm in a place where I'm getting as much from the encounters as my patients are, but that I'm not being sucked dry. That, I learned, can be as detrimental as the physician who doesn't care at all. Now I feel like I'm in truly balanced relationships with myself, my husband, my children, my patients and my students. But finding that balance was tricky and took time. I began to realize that taking care of other people and not taking care of myself is not right. I think we need to teach students and patients that taking care of oneself is a legitimate, desirable and ethical form of caring and important in the MedMap.

Dr. F's story differs from Dr. J's in that its focus is not on setting limits between personal and professional time but concerns setting limits to patient care in her neurological practice.

A CALL A WEEK. Dr. F's Story:

I never feel like I merely have a sick patient; instead I have a family in crisis to deal with. Of course, some patients are truly all alone but this is rare. Others perhaps have estranged members or families "of choice" but most people have at least someone who cares. I deal with the family in a carefully choreographed way, with me as lead choreographer. As part of the ethical approach, I try to set the tone, the limits, the issues, what I want to do and what I need for them to do. Then I get the family's reactions and expectations, what they want me to do and what they need me to do.

As part of the MedMap, I learned to set limits on patient care. Setting limits is very important. I have patients who call me daily about issues that do not need immediate or daily attention. They however, seem to need to talk to me. They are anxious and fearful about being abandoned. I want to be available and supportive and minimize their fear but I cannot meet all their emotional needs, so I set limits. I speak to them supportively and say "I'll put on my calendar to call you next Monday at 5 o'clock." That way we can go for a week between calls.

They know that I will call them. By doing this they sense that I value their concerns and their need to maintain relationships and communication.

Dr. A describes a situation in which she views setting limits with patients as a function of the care perspective in the MedMap. She describes setting limits on the number of people in a family that can speak with the treatment team and encourages appointing "point persons" to reduce complications and misunderstandings.

THE OFF-THE-WALL FAMILY. Dr. A's Story:

As a cardiologist, I often have to set limits. I consider it part of my ethical approach in doing what is right for the patient and for me. For example, I have a patient who is 95 today. A few years ago, she went through some rocky times. She arrested [i.e., her heart stopped], she was resuscitated, she arrested again, was resuscitated again and survived. She has 9 children. They express a lot of emotion. Since we share a common ethnic background I could relate to them on that level. But I was not prepared for their off-the-wall behavior in the hospital, their hovering or their lack of concern for others.

Now when I look back it was rather comical. There were 25 or more people jammed in her room, in the corridors, at the nurses station, all talking, demanding, colliding, each asking the same questions in a different way at different times, then re-asking the same questions. The ICU was transformed from a quiet orderly floor into a madhouse. But it couldn't stay that way. There were too many critically ill patients to accommodate this one family. I was feeling stressed by all the noise, the commotion, the demands and the needs of my other patients. Other doctors and nurses were feeling harassed by my patient's family's behavior and were very upset and angry with me. So in thinking about others and myself I had to take control and set up some ground rules. I couldn't speak to her nine adult children and to each grandchild, too, three times a day. If I did I wouldn't be able to give their mom/grandmother the attention she needed. So I asked the family to designate one point person. At least then I only dealt with one excitable relative.

Do I feel my patient got better care? You bet. Did my relationship with the family suffer? Maybe. Was I caring? Absolutely, for as many people as I thought needed the caring. Was this

ethics? Yes, to me, it was. Some people don't understand that you have to set limits. Not too many people think about all the care that goes into taking care of a single individual: all the discussions with the family, with other physicians and with all the other health care professionals involved.

Dr. D's story differs in that she spoke of caring for herself and her own family. For her, as a pediatric surgeon, setting limits also meant developing professional relationships with persons she could trust.

IT'S HARD. Dr. D's Story:

I went through an early phase of thinking I was the only one who could do anything for my patients. For example, I was giving a talk at an out-of-state conference. My family came along with me so we could be together. My colleague called me to say, "Your 3-year-old patient has taken a turn for the worse and needs an operation immediately. I'm uncomfortable doing the surgery because his family is so bound up with you." I actually flew back overnight to do the operation on this child. In retrospect, I realize I should have talked longer with my colleague to explore what was really going on and to reassure him. He

was perfectly competent to do this operation. I made a bad decision - I flew back here to perform the operation and then flew back to the meeting. It was at considerable cost: to my own personal well-being, to my family, to my colleague's self esteem, and to my continuing professional education. The trips resulted in my being exhausted. I also think I stepped over the limits with my family. I shouldn't have done that. I know I'd never do again what I did. I was not able at that time to say "I'm not available" to my colleague or my patient. I can generally act prospectively now saying "I'm off this weekend." Then on Friday, in addition to my usual ward rounds, I go to patients who might be in need and say "I'm going to be gone 'til Monday. Dr X is on. We will be in touch about how you are doing." It seems obvious to me now, that in order to care for others I must care for myself and my own personal relationships.

Four participants stated they would spend more time with patients but the present health care system doesn't encourage this or reimburse their institutions for it. No participant felt they spent too much time with their families or personal life to the detriment of their patients or students. Six of the participants stated their

family life had suffered at one time or another when the participant was spending too much time at work or bringing work home. All participants believed that caring for others could absorb them entirely, that they could work 24 hours a day, seven days a week, and still have work left over and that there were no limits to this total absorption except as individuals saying "time out, I too have needs which must be met." None of the participants believe, however, that the care perspective caused, initiated or increased this problem. Instead they believed that the care perspective would support their views of setting limits and caring for themselves. Dr. J stated that by caring for themselves as well as for others, physicians create, maintain and deepen their sense of connection between themselves and others. Each participant believed they were entirely responsible for caring for themselves. They did not believe their family, friends,or employers should or could set limits for them. Again and again they stated that they had personal accountability for caring first for themselves and then for others as physicians. One participant concluded, "Physician, heal thyself first."

Summary

All ten participants said their understanding and use of ethics had evolved over time from basically no knowledge to various levels of understanding and application. Nine participants believed their approach evolved to include the

notions of the care perspective. Five participants believed their approaches would continue to change and evolve. Participants believed that the type of relationship that they associated with the care perspective gave meaning to their professional lives. In addition, participants expressed the views that caring for oneself is not only consistent with, but perhaps is legitimized by, the care perspective.

CHAPTER 6

ROLE AND PLACE OF THE CARE PERSPECTIVE IN MEDICAL PRACTICE AND MEDICAL EDUCATION

Participants expressed a variety of opinions on the role and place of the care perspective in medical practice. Among the participants there was general agreement about the care perspective's value as an essential ethical construct in medical practice but several distinct views on its theoretical and practical aspects. In addition, participants viewed the care perspective as an important part of medical education and discussed two closely intertwined notions: 1) making the care perspective explicit in medical ethics education and 2) incorporating the care perspective throughout medical education.

Medical Practice

Participants believed that regardless of whether they identify it as such, they use the tenets of the care perspective in how they think and how they act in situations involving ethical dilemmas.

Theoretical Issues

Nine of the ten participants view the care perspective as an essential ethical construct and acknowledged using the care perspective in their decision making. That is, they consider the individual involved, and they consider that person's life circumstances. Dr. I explained, "I

believe the care perspective is essential to this profession. When I make ethical decisions I cannot just apply principles of ethics. I must take into account the individual. The care perspective helps me define how I am going to relate to others. If you think in a caring way and believe in it as a concept, it pervades all aspects of your life. It fits in with my humanistic and holistic approach to health care." Dr. B stated, "Nowhere is the need for the care perspective greater than in the delicate, almost sacred relationship between physician and patient. To not use the care perspective as part of the MedMap would seem to me to be the antithesis of being a physician." Another participant, Dr. J, said, "What I describe as the care perspective is part of every interaction and every decision I make as a physician, at work and at home. It is part of every patient interaction I have and part of my thinking when making ethical decisions." Dr. F summed it up by saying,

> I see the care perspective as essential to ethical decision making. The physician must be connected sufficiently to the patient and/or family to understand their level of sophistication, their fears and needs, when sharing a diagnosis or treatment plan with them. The care perspective is part of everyday mundane interactions between me and my patients and as

such is part of what I model for my students and residents.

Complementary to the Justice Perspective. Participants tend to view the care perspective as complementary to the justice perspective. That is, they use it along with the principles of autonomy, beneficence, justice and non-maleficence in their decision making. Several of the participants suggested that the justice perspective complemented the care perspective in their MedMap and not vice versa. Seven of ten participants saw the care perspective and the justice perspective as inseparable, but reported that if they had to chose to use only one, they would gravitate toward the core values of the care perspective.

The participants reported that when dealing with real situations they use characteristics of the care perspective (see Chapter 4) sometimes alone and frequently along with the justice perspective. Participants who were familiar with other ethical constructs and theories did not believe there was a conflict with teaching and using the care perspective with other approaches. Drs. H, I and J, who are all generalist physicians, directly addressed this issue.

THEY WORK TOGETHER FOR ME. Dr. H's Comments:

I can't imagine applying only the four principles of medical ethics in the decision making process completely independent of the care perspective. At the same time, I can't imagine that the care perspective excludes consideration of the more abstract, theoretical ethical principles. It is hard for me to believe that they are in contradistinction. In fact they "work" together for me. For example, the ethical principle of autonomy without the care perspective can become a mechanical exercise: "Mrs. X, here are the facts and the options; you make the decision." If I were the patient, I might not see this as autonomy but instead as abandonment which we all acknowledge to be unethical. I believe the care perspective, when used, balances the existing ethical principles. By adding the care perspective here, we could reach a decision which would satisfy the patient, and give her the opportunity to participate in the decision making without feeling a sense of abandonment.

HERE ARE YOUR CHOICES. YOU DECIDE. DR. J'S comments:

For me, medical ethics is nothing very complicated. I think we must be concerned about one another, care about one another and treat one another with respect, trust and honesty. When an ethicist tries to impose pre-existing ethical theories into a discussion about one of my patients, I feel uncomfortable. The ethics of the ethicists sometimes seem foreign to me, mechanical, uncaring of the human being its being applied to. It doesn't mesh with my thoughts, feelings, actions or behavior regarding the person I am treating. And I think that is because of the absence of what is now being called the care perspective.

Take the principle of autonomy for example. In theory it makes a lot of sense to allow people to make their own decisions and give them total say over their medical treatment. But now let's put it into practice. I usually have known my patients for many years. They may have illnesses that lead to death; for example, they may have advanced renal disease with other complications from cardiovascular disease. I completely support a patient's autonomy but that principle omits consideration of so many things. If I am

relying on autonomy I am assuming all patients have a high level of intelligence, a high tolerance for pain, the ability to make decisions and the ability to handle dissenting family members to name a few - even though they are sick and often scared. If I were to use the notion of autonomy but omit the care perspective, I might say: "John, you have a terminal condition. Here are your choices. If we decide to keep you on dialysis, you will continue to suffer from side effects, but if we stop dialyzing you, you will die. You choose." I personally see that scenario as no choice at all. I see it as a physician abandoning a very sick patient and I believe that many of my patients would agree.

TO DO THE RIGHT THING. Dr. I's comments:

I put a great deal of thought into what is right and wrong before making decisions, but I do not use philosophical terms. Most importantly I don't lose sight of the human beings involved. My ethical approach is to keep an open mind, to be sensitive to as many variables as possible. It is an approach that allows me to incorporate the other principles as well as the care perspective in my thinking when I'm trying to make a difficult, important, ethical decision. I

am driven by the desire to do the right thing at the right time. Therefore, I use all my faculties, training and tools to achieve this goal. I am not going to limit myself to one ethical theory to achieve this.

Differentiated from Good Communication Skills. Participants view the care perspective as different from good communication skills. Participants A, I, and C suggest that the caring relationships which develop from the care considerations are not the same as the ability to communicate well. They report that the care perspective reflects something much deeper that enters the decision making process than mere communication skills.

THEY ARE NOT ENOUGH. Dr. A's comments:

In my practice as a cardiologist, good communication skills are necessary, and by that I mean all skills: touch, eye contact, presence, where you sit, what you do with your hands, vocal tone and pitch in addition to the actual words spoken. Necessary though they are, they are not enough. I've never met any physician who can put warmth into her voice, interest in her tone or eye contact unless there is something deeper.

Physicians are not politicians - there isn't any glitz or glamour to a diabetic who

> exercise, where the physician/patient relationship is reduced to "an encounter" - a remote, disinterested encounter - the actual word that is most often used.

Another participant, Dr. C, who is a cardiologist, observed that while some people believe that the care perspective is merely a form of communication skills he sees it as an ethical construct. He said,

> I see the care perspective as an ethical approach because it addresses the issue "what is the right thing to do here." This is what <u>makes</u> it an ethical approach. Of course, this ethical approach does encourage active listening and appropriate responses but it achieves a higher level than merely being able to skillfully share information.

<u>A Pragmatic View</u>. Participants viewed themselves as practitioners not as theoreticians. As such, most participants took a pragmatic rather than a theoretical approach. Only two of the physicians queried expressed interest in theoretical ethical issues. Both Drs. I and J stated unequivocally that the care perspective was an ethical construct and that current ethics theory is flawed because it does not include the care perspective. The remaining eight participants indicated that they were not

really interested or concerned whether the care perspective was an ethical construct, an expression of humanism, or a high level communication skill. They did however state they used the care perspective in their medical ethical decision making and considered it important. One reported, "I don't worry whether it is medical ethics or humanistic medicine. That is not of concern to me as a doctor when I am actually making ethical decisions." Another said,

> I think we [practitioners] take a different position from theorists and I think that is understandable. I am not a theoretical ethicist, I am a physician who must make responsible and practical ethical decisions. I want to ignore this theoretical squabbling and not let it get in the way of my decision making.

Yet another said,

> For me, these theoretical arguments are not particularly relevant in the medical setting. I, as a doctor, am not trying to figure out, as a philosopher might, what behavior at the end of time is right or wrong for a human to do. I am literally looking into the eyes of someone who is very sick, perhaps dying, or into the eyes of that person's loved one and giving my opinion of treatment options. What I want to do at that

moment is to help them through that ordeal, whatever the outcome, because as a healer, I care about these living, thinking, breathing human beings and their pain.

Dr. D explained his position, saying,

> If I looked back at all of my decisions and sat down with an ethicist I'm sure we could identify various ethical principles and considerations that I used. I do not, however, actually think "here is an ethical dilemma. I am going to use the principle of autonomy here." That is just not reality for me.

Practical Issues

Again, as stated earlier, participants believed the characteristics of the care perspective were essential to the MedMap. They also stated again and again through their stories and comments that they use the characteristics of the care perspective in their daily medical practice. They did, however, identify areas of concern. Participants addressed some practical problems surrounding the role and place of the care perspective: () it is not well enough known and it is frequently absent from the MedMap, () it is occasionally misunderstood or misinterpreted, and (3) it is not always applicable.

When the Care Perspective is Absent. Most of the participants said the care perspective is not well enough known and/or is absent from medical ethics theory. They stated or their stories implied that it was often missing both in the MedMap and in the attitudes and behaviors of other physicians they had observed.

Dr. I stated:

> I think there are some very caring, conscientious physicians whose practice is compatible with the care perspective. But there are too few. Many more doctors don't use the care perspective at all. They were never taught it and it's still not taught. I think when the care perspective is absent from medical ethics theory, as it basically still is, the theory is flawed. In reality the principles of the care perspective should be an important part of our ethical decision making process.

Dr. F viewed the absence of the care perspective from the MedMap as a significant problem that adversely influenced patient care and medical training. Dr F., who is a neurologist, called this a what not to do story.

WE HAVE FIGURED OUT WHAT IS WRONG WITH YOU. Dr. F's story:

A 50-year-old man came in with new onset seizures. We found that he had lung cancer which he didn't know he had. It had spread throughout his entire body and was the cause of his seizures. He was a long-time smoker. My attending physician walked into the room with a train of three medical students, an intern, and two residents other than myself. The attending had briefly reviewed the notes of the Emergency Room doctor and reviewed the test results. He had had no prior interaction with the patient. He put his arms across his chest and said "Well, we've figured out what is wrong with you. You are having seizures because you have masses in your head." (You need to know that this patient was an unsophisticated person who didn't know what a "mass" was.) "You have masses in your head because you have cancer in your lungs and that is because you smoke so heavily." Then he turned and walked out the door followed by all of us.

That was it. That was the extent of the consultation. That also was part of our medical training. I was the senior resident on service and felt very uncomfortable. Later, I told the

residents and medical students that we had to go back in there after attending rounds were done and "fix things." We had never told the patient in words he could understand what was wrong with him. We never let him ask any questions. We made him feel guilty and completely responsible for his disease. Now, even if we believed his behavior caused his disease that wasn't the time or way to tell him. I thought it was unnecessary to add this pain to what this patient already had to cope with.

Here is where the care perspective should have been used. It was not. That physician treated his patient terribly and unethically. I felt very uncomfortable all day. I did finally go back to "fix" it, but the damage was done. No one after that was able to establish a mutually satisfactory or bonding relationship with him. I never felt he trusted any of us again. Damage was done by not using tenets of the care perspective. The first encounter isn't always critical but in this case, it was.

Several of the participants suggested that the MedMap can erode into a mechanical exercise limited to disease detection and technology application, if physician/patient relationships are established without philosophical

grounding in the care perspective, or when physicians are making ethical decisions without including the care perspective.

Dr. B who is a family practice physician expressed concerns that when the care perspective is absent, decisions can be made or actions taken that cut the patients off from loved ones or from services or benefits. He noted:

> Our health care system is not particularly kind to elderly people who are still sick but no longer need hospital level care. We bounce them out of one environment and stick them in another as quickly as possible once their care is no longer being paid for. Sometimes our decisions disrupt the relationships or the support systems that are in place for these individuals. For example, suppose you are in the terminal phase in your life. You are having to make transitions and adjustments at a very intimate level. You need people to assist you with basic bodily functions, eating, sleeping, toileting, and turning in bed. For the very old and very ill, it is a very difficult transition to make from a hospital to a non-hospital setting. Instead of receiving help, you are told, "you can make your own decisions and we will respect them and, oh, by the way, you can't stay here because you are

not considered sick enough to be in the hospital."

Dr. I who is a family practice physician feared that an important ethical concept, that of obtaining informed consent, becomes a repetitive and redundant ritual when the care perspective is absent.

DANCE OF DISCUSSION. Dr. I's Comments:

> Often when we [physicians] are making ethical decisions, we engage in a dance of discussion hiding around phrases such as autonomy and informed consent. We don't get down to basic understandings. We engage instead in elaborate posturing. We may talk about and think they are obtaining informed consent and respecting the patient's autonomy without fully exploring the patient's true level of understanding and ability to act and consent. We think that there is a common understanding but we haven't really explored to see at what level the understanding does exist.
>
> Sometimes there is so much work to do that obtaining informed consent and respecting autonomy, although they are important ethical considerations, become rote for us. We may shortcut some of the communications and just say,

"Read this. Any questions? Sign here"; and it's over and done with; it is purely mechanical. We doctors do not intend for it to be that way but I do not know how many times people can go through it afresh.

I really do not know how many times doctors or nurses can go through grieving with a patient or family either. We do it and many of us do it successfully but it is very hard to do when your beeper is going off because of a crisis with another patient and you have three residents trailing you.

I believe if you have the tenets of the care perspective drilled into you through your early classroom and practical training, you may stop and say "Wait a minute. I know I've seen 20 young men die from AIDS and this death will be similar <u>but</u> it is not the 20th time for my patient, it is not the 20th time for his loved ones. I care about this person so what can I do to ease the pain?" If we always think of the care perspective it will give us the fortitude to take time with patients, handle conflicting demands responsibly and show medical students by our example what being a good and an ethical physician is all about.

Dr. B's thoughts and story echo Dr I's concerns about the process if the care perspective is absent. Many of the ethical issues he deals with come to the fore around "do not resuscitate" (DNR) issues. Federal law requires that patients be informed of their rights to make choices regarding continuation of care or termination of care (that is, patients can choose a DNR code status). Institutions require these "advance directives" on code status from their patients. According to Dr. B, "Obtaining these advanced directives is a very important part of the MedMap, but if it is done without the care perspective it can become mechanical."

JUST A MECHANICAL EXERCISE. Dr. B's Story:

In my practice I have some nursing home patients. As part of its licensing and accreditation process, the nursing home was required to know the DNR status on all patients. I had discussed DNR with all my patients except for one. Each time I had seen her over the last 3 years she'd tell me that she hated the nursing home, she hated being there, in fact, she hated me because I put her in the nursing home - which was not true. Because of her hostility I decided not to discuss DNR with her. I justified my decision by saying, "she's not ready yet." The nursing staff and administration of the nursing

home were upset with me because the re-accreditation process was nearing. I continued to think about this issue and planned to bring it up when the time was right for her. Meanwhile I had decided that if she needed to be resuscitated it would be done. I made the decision without consulting her because of her hostility and paranoia. She often said she believed that people in the nursing home were trying to kill her. I felt she had enough issues without burdening her with DNR.

Then one day we were having our usual conversation about her hating to be in the nursing home. She said "I wish I was dead." This was the opening I'd been looking for. "Ms. X, that's a tough thing to say. We need to talk." We talked about death and dying. We talked about if she died. I discovered that she would very much like to be DNR. I actually had thought she would want absolutely everything done for her in the way of resuscitation, but she said "if I die, leave me alone. Let me die and finally I'll get out of here."

We clarified some things and I felt that I understood where she was coming from and that I had helped her. Maybe because I cared for her and wanted to do what was right by her, I

shielded her from this painful discussion, until the time was right. The way I approached the discussion felt pretty good to me and to her. I hadn't responded to a cold administrative demand but I waited till Ms. X was ready. I probably could have had this discussion with her on a purely mechanical basis much earlier, either when I first met her or when I was asked to meet the nursing home's licensing requirement. But I believed it wouldn't have gone well at all and may have interfered with my ability to provide her with further care.

Clearly you can't have these discussions without having a relationship as a foundation upon which you can build. Often when a patient comes into the nursing home she is at death's door and grasping for hope. And here I am, talking about no resuscitation, and letting you die. It's worse than asking "do you have insurance" before you treat someone. I can't do it that way. I feel that it is so unethical. It is so mechanical. I have to develop a relationship before I can have a meaningful conversation with a patient about her death. The patient can then appreciate that the discussion doesn't mean I am abandoning him/her. I am not waiting - like the heirs in the wings for her

cash - anxious for her life to be over. The discussions mean I am willing to listen and care for him/her. We can talk about death and dying if the relationship is there ahead of time. Without the relationship, without the trust of the patient and without the doctor having a real understanding of the patient, the family, their values and the circumstances, it is hard, perhaps impossible, to discuss these advance directives. Without the care perspective, I think it can become a purely, mechanical act.

Participants in general believed that when the care perspective is absent physicians could easily ignore other important relationships. Nine of the ten participants indicated that they had only recently begun to think about the ethical implications of how they, as physicians, treat other health care providers. They noted that they and many other physicians did not pay much, if any, attention in their MedMap to their relationships with other health care providers.

Dr. C, a member of the hospital ethics committee and a leading medical educator, suggested that the absence of the care perspective adversely affects interactions between health care providers. He argued that if the care perspective were part of early medical training, reinforced

at every step, it would be hard to ignore relationships with other health care providers. He stated,

> Then we would know how important it is to build and nurture these relationships. We would ignore these relationships at our peril. To ignore them would then be against our training and conscience. As it now stands, it is implicitly okay in our profession to ignore the wisdom and care other health care professionals provide.

When the Care Perspective is Misunderstood or Misused. Participants mentioned instances of where the care perspective is misunderstood or where it could be misused. Six of the ten participants mentioned that the care perspective is often seen as a feminist and/or nursing approach to ethics and dismissed as such. Several felt that the care perspective is hurt by its close association with feminist and nursing literature. Each was careful to say it did not affect his/her personal views of the care perspective, nonetheless each believed that one reason the care perspective was not considered a mainstream ethical concept is that it was first noticed and written about by what are commonly seen as "fringe" groups rather than being first brought out as an explicit ethical construct in publications like the New England Journal of Medicine or Journal of American Medical Association (JAMA). Drs. A and

I believed the care perspective was easily dismissed or trivialized as the views of a "special interest" group.

Participants expressed concerns about another type of misunderstanding. They felt that the care perspective might be misunderstood and/or misused to justify certain behaviors in the area of protecting other physicians. Participants reported that the bonding relationship between peers or colleagues in medicine is often seen as a primary moral obligation and because of this bonding relationship, physicians refuse to "betray" other physicians. Dr. I expressed her concerns and stated, "In such cases, physicians may mistakenly think they are being caring and doing a colleague/peer a kindness by not reporting unethical behavior and may through a serious misunderstanding invoke the care perspective and misuse it."

Dr. A, a cardiologist with many years as an administrative medical educator, gave an example of what she called "misguided caring."

MISGUIDED CARING. Dr. A's Story:

> We had a resident, i.e., physician in training, who did many irresponsible things. In addition, he lied about what he did and didn't do while caring for patients. He left the hospital when he was on duty and he left his interns and

students in the hospital alone while he went home for dinner.

His ethical standards really troubled me. But in addition to his actions, it was the misguided "caring" of his peers that also concerned me. It's strange. I believe physicians still cover up mistakes or flaws of other physicians. I find them saying "I really don't want to harm him. What will this cost him in terms of his career?" rather than asking "is this doctor being ethical, professional, competent?" or asking "am I showing a caring concern for this doctor by overlooking his flaws?" Physicians seem to feel very strongly about the protection of peers. I try to tell them that they need to give honest positive and negative feedback. In this case, people were honest with me about this resident when talking to me one-on-one but they absolutely refused to put it in writing. Finally I bit the bullet and fired him. I could not excuse, justify or ignore his unethical behavior.

Several other participants described similar experiences as Dr. A and expressed the "fear that physicians could misuse the care perspective to justify this type of abuse." Dr. A stated that

. . . residency training programs are the last golden window of opportunity to make any kind of interventions in medical training. It is much more difficult once the doctors are out in practice. Among our peers we have a very difficult time reporting what we think are instances of poor care, unethical behavior or substance abuse.

Therefore, we must teach the care perspective and its correct use in medical school. I'd like to use the care perspective appropriately to change and rehaul the entire peer review system. I believe it would revolutionize our thinking so that we realized true caring meant not hiding the abuses of fellow practitioners. Instead we would get them help and training to suit their particular problems and needs.

Dr. A gave another example of what could be construed as "misguided caring."

THE LAST GOLDEN WINDOW. Dr. A's Story:

We had a resident in our program who had a problem with substance abuse unbeknownst to me. It was brought to my attention in an unusual way after another resident committed suicide. After

his problem was identified, and I began questioning his peers, some came forward and said they had known all about it but had not said anything. They felt that they would be betraying him. I couldn't quite understand it. I felt heartsick that it took a suicide to bring them forward.

As a contrast, Dr. A gave a different situation - one where she felt the care perspective was not misused:

> One of my residents was a very bright individual who just was getting in his own way. I'd get phone calls from nurses saying he was openly rude when questioned about an order. Some complaints came from nurses who wanted clarification of treatment plans; other complaints came from nurses who actually were questioning the advisability of the order. He would respond "Just do this. I'm the doctor." He also did not function well with his peers, especially his female peers, or with me, as a woman in a position of authority. I met with him on many occasions to discuss his behavior but was getting nowhere with him. The promotions committee had real concerns about promoting him. Although he was very proficient in medical knowledge, there were concerns about his way of

relating to patients and to the medical team. If promoted, he would move to the next level where he would be teaching and supervising medical students and residents. How would he run a team that includes women medical students? How would he interact/treat patients, given his past performance? We delayed his promotion. We got him help so that he could understand why he was not promoted and what he would need to do to get his promotion. This is an example, I think, of the care perspective working properly amongst colleagues.

<u>When the Care Perspective is Not Applicable</u>. Participants discussed some instances where they could not see the applicability of the care perspective. Some have already been mentioned, such as peer protection. Not even its strongest proponents among the participants felt the care perspective is a panacea for all ethical issues and problems. Each of the participants stated that sometimes the care perspective does not seem applicable or "does not work" and each reported at least one experience as an example: (a) when the patient's needs are not medical; (b) when the patient does not want to get better; (c) when the patient is hostile; or (d) when the patient's or student's actions are perceived to be illegal or unethical. In each of these situations the physician chooses not to use the

care perspective to build a bonding relationship and/or to continue a relationship with a patient or student.

Several participants stated that there are times when a patient will demand treatment which they, as physicians, can't ethically provide or will exhibit a behavior or attitude that they as physicians can't ethically respond to.

I FEEL LIKE I'M RUNNING ON ONE LEG. Comments by Dr. H:

There are some people who do not want to get better. There are lots of reasons for that. First, there are those patients who just want to be "taken care of" indefinitely. These patients are too needy or too dependent and therefore do not want to get better. They have a pattern of learned helplessness which is very destructive. Many want the physician to "do something": write a prescription, order a test, or recommend this or that therapy. They feel unfulfilled if they go away without something even though they need nothing medically. I ask myself is it ethical to provide unnecessary medical treatment just because my patient demands it or thinks he needs it?

Being asked to provide treatment under these conditions makes me feel like I'm running on one leg. I feel exhausted, helpless, angry, and unfulfilled as a professional. I cannot and do not develop relationships with this type of patient. I see this as an example where the care perspective does not and cannot work.

The next story by Dr. F, a neurologist, echoes this theme:

THEY JUST SUCK OUT ALL MY ENERGY. Dr. F's Comments:

My agenda is usually to figure out what is wrong with my patients and to help them get better. I want them to know they can do to improve their situation. Although I can help my patients with things such as prescriptions, my main job is to get them to look after themselves. I know this is the right and moral thing to do.

The most frustrating patients for me are those who for their own reasons do not want to get better and really do not want anyone to <u>cure</u> them. I feel like I'm wasting my time. It takes a lot of energy to interact with these patients and I feel like they just suck out all my energy.

I have a hard time using the care perspective in these cases.

Two participants, Dr. E, who is a neurologist, and Dr. G, who is an orthopedic surgeon, commented on situations where the patient or a significant family member is too hostile and they were not able to use the care perspective.

I WOULD SAY APPLE AND HE WOULD HEAR LIGHT. Dr. E's Story:

Mrs. K has an expressive language problem, a history of significant depression and a very angry husband. The woman's inability to talk was problem number one. We couldn't determine exactly why she couldn't speak; perhaps it was because she had had a stroke. Problem number two was Mr. K's hostility. At first, I thought he was frustrated because doctors couldn't make his wife talk again. As time went on I sensed that this was a man who angers easily with or without a reason. He would often listen to a little bit of information and then lash out at me in anger.

I can usually establish a relationship with a patient who is unable to speak, even when s/he is lying in bed - sometimes by stroking his/her brow, making some soothing sounds or fluffing up his/her pillow. I have learned to use non-verbal

ways of communicating to convey a sense of concern and that I care. But I found it next to impossible to establish a relationship with this particular patient with her particular illness and her spouse.

I was willing to try. I knew that we each needed to understand the basic facts and then agree on what needed to be done. I listened as the husband expressed his anger, assuming he might be helped by venting some hostility. I did not take the hostility personally but I felt that it certainly got in the way of any productive relationship. The problem then deepened and worsened - although I didn't see how it could - it did. I soon began to realize that the husband was so angry that he could not understand me. I would say apple and he would hear light. The encounter became not only unproductive but possibly even hazardous and, to date, our relationship has improved very little.

Dr. G also addressed hostile patients in relation to the care perspective.

I FIND MYSELF TALKING LONGER AND HARDER TO MYSELF. Dr. G's Comments:

I find myself talking longer and harder to myself about treating difficult patients. Some patients are so demanding and hostile about their situation. They direct their hostility at me as their physician as if I'm the person responsible for them being ill or in pain. They are looking for someone to be at fault. Patients have to take a certain amount of responsibility. When they refuse to do that, when they aren't able to accept their situation, or when they direct their anger toward me, it is very difficult for me to care about them. I worry that a few might try to hurt me or my family. All these are barriers to caring and to building and nurturing a relationship. I feel hobbled. That is when I find it takes me talking to myself longer and harder about my ethical responsibilities to these difficult patients. I'm not really sure how to handle these patients and the care perspective doesn't seem to give me guidance.

There are other cases where the participants felt the care perspective was not applicable as an ethical construct. Participants state, not unexpectedly, that they are not able to use the care perspective or the care

considerations to establish relationship when they perceive a patient's or student's needs or actions are illegal or unethical. Dr. F who is a neurologist described it as "patients or students having an agenda that differs from my own."

A LEGAL AGENDA - I OFTEN FEEL STUCK. Dr. F's Story:

Some patients have a "legal" agenda. They want to sue someone or file or extend a workman's compensation case. They're not motivated to improve or get well because they want to get their monetary settlement.

We get a number of legal cases here because we have an Emergency Room. Many other cases come from physicians in the community who will not take legal cases and refer them to us. I often feel stuck. For me, the ethical dilemma arises because I'm treating a malingerer. I am motivated to treat and to heal people. I try to do so independent of all monetary concerns - mine or theirs. When these legal cases are referred to me I find it difficult to be objective. Whenever a patient isn't improving, I ask myself is it the treatment plan or is this person purposefully malingering or creating sympathetic symptoms (a neck injury, for example)? This

makes my job especially hard. In many instances, my patient even says upfront "I'm mad about this injury and I want you to help me get all I can." Well, as a doctor and as an ethical person I cannot be a part of this. I dread these cases. I do not see how the care perspective can work here. At the outset I have no trust or interest in developing a caring relationship. Yes, I also worry that they'll try to sue me, too. That's definitely a factor. It puts me on edge. It's stressful to think there are lawyers and a patient watching my every move, critically looking for any mistake or omission I may make, however small.

Participants also described other situations where they felt the care perspective is inapplicable. The hidden agenda can be a sexual agenda in which patients make conscious or unconscious sexual advances. They indicated that unethical behavior by patients, including sexual overtures, inhibits or even prohibits the type of caring relationship that is part of the care perspective.

A SEXUAL AGENDA. One participant's story:

> I have a patient who is too friendly with me. She is physically handicapped. She is also sexually inappropriate with me in the examining

room. She would never fall down in the exam room or fall into things but she falls into me to have full bodily contact. Therefore, I stay physically more distant. Her needs, as she expresses them in these overtures, are very different from what I am offering. I sense that she really needs a friend and that many of her issues are those of loneliness. I detect an underlying depression connected to her disability and have suggested that she see a psychiatrist, which, to date, she refuses to do.

I have not discussed her behavior or my discomfort with her sexual overtures directly with her. It would be embarrassing to both of us. Perhaps that would be the most ethical thing to do. Maybe I will someday. From the outset I have felt that this patient has made inappropriate and unethical sexual advances. Therefore I don't trust her. I want to refuse to treat her but I have a very hard time doing that. I don't see how the care perspective would help shape or mould this encounter. Perhaps if the care perspective had been part of my training all along I would be able to use it here but I just don't see how right now.

Finally the participants believed the care perspective was inapplicable when patients were simply dishonest. This becomes a barrier to establishing the relationships or using the care considerations. One participant described a situation with a student in which she had attempted to use the care considerations to build a working relationship but was not successful due to dishonesty. Dr. A, who is a cardiologist, described a resident, that is, a physician in training, who was both fraudulent and negligent in her duties.

SHE JUST DID NOT GET IT. Dr. A's Story:

I train and certify residents as physicians competent to practice medicine without further supervision. Therefore, when it is necessary, I have to deal directly, immediately, and emphatically with inappropriate attitudes or responses. Unfortunately, there are some failures and I've had to let some people go because of their unethical and unprofessional behavior. We had someone in our residency training program a few years ago who was very smooth. She was a first class liar; she said she did things she didn't do. She failed to order medications but said she had, and did other irresponsible things. The department chair and I met with her on many occasions. We sent her

copies of our notes and summaries of our concerns. She just didn't get it. Finally she lied one too many times. We terminated her and reported her to various licensing boards. There is no pleasure in that except that I knew I had met my responsibilities. This is a person who should not be a doctor and now she won't be. We felt that this kind of person - unless she was under constant surveillance - was dangerous.

From my understanding of the care perspective, which I have never studied formally, we should have taken certain steps toward building a relationship with this person. But as I see it, both parties must work together to build the relationship. What is the ethical approach with someone who chronically lies or who otherwise behaves unethically? I won't say unequivocally the care perspective won't work under these circumstances but I cannot understand how one is to build a relationship or bond with a person like this. I'm not sure what the care perspective approach would be to this type of problem.

Summary on Care Perspective in Medical Practice. There was general agreement by participants that the care perspective has an essential role and place in the MedMap

in medical practice. Participants addressed some theoretical issues surrounding the care perspective: they view the care perspective as complementary to traditional ethics and as more than good communication skills. In addition, participants also described a variety of situations where they were unsure of the role of the care perspective. These included occasions and circumstances where the patient does not want to get well, has an agenda the physician does not agree with, is hostile or engages in behavior which interferes with treatment. Many admitted that they did not know how the care perspective would be used in circumstances such as these.

The Care Perspective in Medical Education

A majority of participants said that the care perspective should be part of medical ethics education given that it had an important role and place in medical practice. They felt it should be explicitly taught through both classroom training and clinical training. Most participants made statements akin to those made by Dr. B who stated,

> We may be training practitioners to make ethical decisions with tools they won't use, while ignoring an important one which in practice we do use. Now that we have decided our medical students must be taught ethics, we must also include the teaching of the care perspective.

Other participants also suggested the care perspective should be taught over the entire course of a medical student's education and not sidelined or compartmentalized into a single course.

Participants described three attitudes that would influence the inclusion of the care perspective in medical ethics education: (1) appreciation of the role and place in medical practice; (2) recognition that the care perspective does conflict with traditional medical education; and (3) a willingness to accept alternative approaches to the MedMap.

Participants expressed the view that the role and place of the care perspective in medical practice needs to be appreciated by the medical profession. Most of the participants discussed both the importance of and implicit nature of the care perspective in their practice. They suggested that the characteristics of the care perspective are the foundation for ethical decision making. Dr. A stated,

> I think the care perspective approach fills a void in medical ethics education. Our objectives would be to teach very clear standards and expectations about treating the patient as a person in relationships with physician, family, other health care providers and not as an isolated unit or a disease or illness.

Throughout the interviews, participants noted the conflict between medical education as it exists and the care perspective. Dr. E stated:

> There was and still is a tension between the way doctors are educated/socialized and the care perspective. I think that there have been several things that explain this tension. All the reading and training in medical school is on diagnosis and treatment. This pretty much has channeled us and established a mind set that is hard to break after four years. Residency really re-emphasizes it. During all these years, we are trained to look at only one part of a patient: the organ system and to overlook a more holistic approach to a person's life.

Along similar lines, Dr. C observed that there is "a bias in medical education toward scientific fact, technology and disease rather than compassion and a bias in favor of 'disinterested concern' rather than empathy."

Seven participants expressed concerns that only one ethical approach was taught. Dr. I stated,

> Training in medical ethics emphasizes the values expressed through the justice perspective at the expense of the values expressed through the care perspective. In medical practice our treatment plans are individualized as we

> recognize that patients' physical and emotional responses vary tremendously. In medical ethics, I think it is unrealistic to have and to teach a single set of rules to apply to every one.

Nine of the ten participants suggested that physicians and medical students need to have a willingness to expand the concept of ethics to include what they called "low-tech ethical ideas" or non-"heroic" ethical issues in training. As previously discussed, several suggested there was too much focus in medical ethics education on what Dr A. called "the 'sexy,' 'media grabbing,' '911' types of crises" and not enough on the day-to-day issues in current medical practice.

In general, participants thought the care perspective should be taught explicitly and incorporated throughout medical education. Several participants specifically suggested that the care perspective belongs in the total curriculum and should be integrated throughout both medical ethics education and medical education. They then discussed the issue of evaluation.

Integration

Dr. H stated:

> In order to teach ethical behavior we must require ethical approaches, like the care perspective, to be integrated in medical ethics

textbooks and also into the entire educational process. In most cases medical ethics is offered in a single course, or a series of seminars. If we are serious about medical ethics, and about the care perspective and I think we are, we must treat them very seriously and incorporate them throughout medical education.

Dr. E commented:

In order to value medical ethics in general and the care perspective in particular, we physicians should recognize our biases toward science and technological answers. We must not discount something that may be essential in the MedMap. We, as educators, are remiss in focusing exclusively on one knowledge base and evaluating performance primarily in specific course content such as pharmacology or orthopedic medicine and one set of skills such as clinical skills, procedural skills, and technical skills. Part of our mandate as medical educators is to remember the ethical considerations at all times. I think the care perspective offers us some direction by constantly reminding us of humanistic concerns.

According to Dr. E,

> Faculty need to help medical students develop ethical approaches to patient care. Training in ethics would include, behaviors and actions that are associated with the care perspective. This training would be present throughout the entire curriculum.

Evaluation

Dr. H, however, raised the problem of evaluation of the care perspective in medical ethics and in medical education and stated:

> I believe we need to practice the care perspective and to teach it but we would need some way of evaluating, tracking or measuring its use by physicians and medical students. We can test knowledge in scientific facts and in technical skills. We need a way to evaluate the care perspective in ethical decision making. For the care perspective to be accepted as a formal part of medical education, we would need evaluating and measurement tools.

Instruction Methods in the Care Perspective

Several participants expressed the view that the care perspective could be included in medical education using

different modes of instruction. They suggested modeling by physician-educators and formal classroom instruction.

Participants stated that one way to successfully train students in using the care perspective in the MedMap is through modeling. Dr. A stated,

> . . . students need to be exposed to people who use the care perspective and who model it. When we attend on wards, a major part of our responsibility is teaching. This includes showing students how to relate to patients. I believe our educational programs should teach the importance of relationships and how to foster relationships. What I'm imparting to my patient as we are sitting and talking, I am also imparting to my students who are sitting with us at my elbow. Right now, it is really the luck of the draw as to who becomes the role model. The behavior the students observe tends to perpetuate itself. Therefore, as role models, we should teach very simple responses to the patient [as a person in relationship] including, among others: returning telephone calls promptly, setting clear limits so that all know the expectations. Our modeling should also include instruction in some very specific behaviors: where you sit or stand in the patient's room, how you address the patient, peers and other staff. I have found

that when we use these behaviors we have fewer and fewer problems.

Dr. D commented,

> In addition to the simpler responses there are complex ethical issues that involve many people in varying types of relationships, with many types of conflicts. My underlying principle is that there is no issue too deep, too heavy or too complicated for students. I have my students stand by to see, to listen, to question what is going on because that is how they learn, not in a classroom but in real life situations. For some faculty the standard approach would be: "this is a tough situation - too tough for students. They can wait outside while I take care of it." I disagree. I try to bring students into all situations. They can see me building relationships with my patients and their families; meanwhile I'm building relationships with my students.

In an example from her own teaching experience, Dr. F described what she called the ethical way of interacting in a caring way with a person who has a chronic or terminal illness. Every year she demonstrates to 100 students in an amphitheater how to build relationships with a patient and

patient's family and how to use considerations associated with the care perspective.

JUST DOING LOTS OF LITTLE THINGS. Dr. F's Story:

In a large class setting I demonstrate how physicians should interact with patients. The students have had lengthy preparation on the type of medical problem the patient has and they make a preliminary diagnosis. Then they get to meet the patient and the patient's family and ask questions. Having the patient present is unusual, but it is a very important part of modeling.

John had a severe stroke at 55. He came in really sick and could have died. I told that to his family. Later he made some improvement and it looked like he might live. Ultimately he did not die, but he was severely disabled. He had severe and permanent left side paralysis. He also had seizures. When he returned home, he was unable initially to care for himself. Although he is able to care for himself, he has lost the ability to make good judgments now, as a result of the brain damage. This puts a lot of strain on his family. He is also unable to work.

I shared my entire treatment history with my class. I took care of John in the hospital and

then in rehabilitation so I had two months of frequent interactions. This is an intense relationship by its very nature. When you have had a devastating illness that leaves you with a disability, not only do you own it but your entire family owns it. I try to teach my patient how to take care of him/herself to the extent of the abilities he/she has and also teach the family how to make up for things the patient can't do. In this particular instance the family consisted of John, his wife and two teen age daughters. They were a tight family unit that became even tighter when the patient was in rehabilitation. First I had to figure out what he could absorb. In a rehabilitation hospital you must help patients understand what happened to them and how they need to modify their life style. We worked on educating the patient and family through this entire process. We developed strong physician/patient/family relationships by speaking to the patient's level of understanding, answering questions truthfully for the 55th time, talking on the phone, doing whatever needed to get done. Just doing lots of little things.

When presenting John to my students I must maintain his dignity and modesty. I am not able to predict what the students will ask or predict

how he or his family will respond. John, as a result of the stroke, can't always control his emotions. Students often wonder why he cries or has outbursts of anger when asked a simple question. The crying and anger are difficult for John, his family, for many of the students and even for me. When this happens I may have to intervene and redirect questions. I try to demonstrate a comforting gesture to John or his family, expressing empathy. It might be a hand touch, getting closer, or redirecting the conversation. That's an important skill to learn when you are physician. You have to know when to make emotional contact, and when to draw back a bit and let the patient have the space to regain control and dignity.

John's wife and daughters were willing to share their feelings about their changing roles from wife and child to caretaker. His daughters went from having Dad look after them to having to help him dress, go to the bathroom and care for him in ways that were very personal.

It was a great experience for the students to learn in depth about a family, to see the follow up and to observe the existing relationships. It seems also to be beneficial to the patient and family because they've been

willing to return several times. I only regret that this formal modeling occurs once a year for one hour. It is just not enough. This type of formal modeling allows students to observe me, critique my actions and ask questions. Of course, modeling good relationships should be occurring frequently and consistently in daily rounds.

Only one participant discussed formal training in the care perspective and gave an example of when she thought it could take place.

A TEACHING MOMENT. Dr. J's Comments:

I believe we were using the care perspective implicitly during a recent AIDS Symposium. We could have and should have explicitly discussed the care perspective the next day in a more formal way when we were assessing the events.

At the AIDS symposium, medical students saw and heard very personal experiences of people living with AIDS. One patient with advanced AIDS implored us to "build essential skills." The skills she mentioned were how to care, what's the right thing to do and what's the right thing to say to AIDS patients. As you know you can't just talk to students about developing skills; they

have to learn how to do it, they have to see other people doing it.

On both days the sessions ended at 5 PM. Almost all of the students were still there when I left at 7, still talking to the patients. The patients were sharing their stories, expressing their emotions; some of the them, patients and students alike, were crying. Within a very short time period students were showing the considerations that are part of the care perspective and were building relationships with some of the people with AIDS. I left thinking these students need to have this type of educational experience more often. Where else are they getting this in their medical education?

This annual Symposium always gets rave reviews from the medical students and they say "we want more of this, give us more." They say they are hungry for these deep, feeling, personal interactions with their patients. They also love the patient feedback.

To me, when educators see students expressing their emotions, even crying with patients, experiencing a sense of bonding relationship, then this would be the opportunity for introducing the care perspective more formally as an approach to the MedMap. Here is a

"teaching moment" when we could formalize an analysis of what was happening. We could have made the care perspective explicit in a follow-up session, but we didn't.

Drs. A, C, E, and H believed that the care perspective should be integrated throughout medical education. They then went beyond that step. In a radical departure from what they called tradition, they envisioned teaching medical ethics collaboratively with other health care providers, thus making it multi-disciplinary. Drs. A, C, E, and H believed that the care perspective should be included in any collaborative program.

For example, Dr. C suggested that physician-educators and nurse-educators could collaboratively teach ethics courses that would include the care perspective. The courses could be taken jointly by medical students and graduate nursing students.

These four participants recognized that each group would contribute its own values and insights. The groups would learn ways to cooperate with each other in making clear, ethically sound decisions for and with patients. Dr. A stated,

> Often when ethical impasses arise, it is between health care providers. They have a hard time coming to resolution because they do not know where the others are coming from. I can

envision the educational process for health care providers (as well as the medical care for patients) as a more unified process rather than the compartmentalized process that it is. I think medical ethics education needs to go in this direction. Mutual understanding and respect would be enhanced if medical and nursing students worked together in a unified education program.

Dr. C commented,

In my own experience I've observed that other health care professionals, especially nurses, commonly have bonding experiences with patients. My belief is that nurses have a great deal to share with doctors in terms of their knowledge. Physicians obviously have a different set of approaches to certain kinds of medical/ethical problems but each discipline has something to offer the other and it seems to me that it is very desirable to bring these two disciplines together. I think it would be very desirable to have a joint medical/nursing ethics education program where we will have medical students and residents learning together with graduate nursing students. This would bring students of two different disciplines and of relatively equivalent levels of education

together. Many of the nurses in the graduate programs have already been nurses on medical floors. These nurses have valuable experiences to contribute.

Along similar lines, Dr. A commented:

> Physician and nurse educators could teach medical ethics collaboratively. It would be a very exciting way for medical students to learn the care perspective. They would be hearing about it from nurses who are already very familiar with it and also would have the chance to practice it themselves. It is important to remember that we deal with medical students who have not had much clinical experiences. Nurses have a wealth of clinical experiences and have faced a number of ethical issues that they could share. They could also teach students to take a broader approach to medical ethics.

These participants offered other specific suggestions for a collaborative effort in addition to joint training in the care perspective with other health care professionals:

1. joint orientations for interns and residents with other health care professionals with emphasis on relationship building;

2. practicing the care perspective by using case studies; and
3. developing an evaluation process of the care perspective that would include evaluations from other health care professionals.

Summary to the Care Perspective in Medical Education

In summary, a majority of participants believed the care perspective had a role and place in medical practice and in medical ethics education. They indicated it should be made explicit and be extended over the entire period of a medical student's education and not compartmentalized into a single course. They stated the care perspective should be taught through classroom instruction and medical training, although they provided very few specifics about methodology or evaluation. Four participants stated that the care perspective could be taught through collaboration with other health care providers and disciplines.

C H A P T E R 7

CONCLUSION

Summary of the Findings

In this particular study, I focused on the following areas: physician-educators views on the care perspective in the MedMap and in medical ethics education. Although all participants were chosen because they had some knowledge of the care perspective, I did not know how they regarded it, understood it or used it, if at all.

The findings can be summarized as follows: Participants believed there were three characteristics that they commonly connected with the care perspective and that they believed distinguished the care perspective from other ethical responses. The first was considering the person within every patient. The second was considering and respecting a variety of relationships. The third was considering the context of the patient's life experiences. One participant called these characteristics "care considerations." Participants believed that these characteristics are the foundations upon which ethical decisions should be made. They believed that these characteristics distinguish the care perspective from other ethical approaches, although they did not always clearly distinguish them one from the other in their stories or comments. Several of the participants were aware that one

characteristic led to another and were sometimes blended together (see Chapter 4).

All ten participants said their understanding and use of the care perspective in the MedMap had evolved over time. For these participants, evolution was not a passive process, but an active one, where participants took great pains to learn more about medical ethics and to reflect upon the practical application of medical ethics. Nine believed their present approach included, at the least, some characteristics of the care perspective. In explaining this evolving process, participants described their experiences with the care perspective in their medical practices. Although one could see the evolution as a natural consequence of experience, participants had to be open intellectually and emotionally to hear theories, different approaches and to learn and incorporate new approaches with old. These participants identified the conflict they saw between traditional medical ethics education and their new ethical approaches which now contained characteristics of the care perspective. Participants discussed the enrichment of their personal and professional lives through the care perspective. They believed their lives were also improved through caring for oneself which several described as a tenet that is not only consistent with, but perhaps is legitimized by, the care perspective (see Chapter 5).

There was general agreement by participants that the care perspective is essential in the MedMap. They viewed it as complementary to traditional medical ethics theory rather than as supplanting or replacing it. Participants also gave voice to some practical issues regarding circumstances or situations where they were unsure of the role and place of the care perspective.

Of equal significance, a majority of participants believed the care perspective had a significant role and place in medical ethics education and some felt a role and place of equal importance in the broad area of medical education. Participants described three attitudes that would influence the inclusion of the care perspective in medical ethics education and in medical education: (1) appreciation of the role and place of the care perspective in medical practice; (2) recognition that the care perspective does conflict with traditional medical ethics education; and (3) a willingness to accept alternative approaches to the MedMap. Participants believed that the care perspective should be made explicit in the MedMap; be taught explicitly in the classroom and modeled and understood in the clinical setting; be extended over the entire period of a medical student's education and not compartmentalized into a single course. Four participants went further and stated that the care perspective could be taught through collaboration with other health care providers and disciplines (see Chapter 6).

In summary, these findings clearly indicate that some physician-educators believe the care perspective is important and implicit in medical practice; is essential to the MedMap and must be made explicit in medical ethics education.

Findings and Literature

One problem came into sharp focus for me in both the literature review and in the findings. The care perspective in relation to medical ethics has not yet been clearly defined. That is, there is not yet one standardized term or definition used by all for the care perspective. Furthermore, some of the terms that are used, those of care, caring and relationship, have many definitions and usages, but especially so, within the medical profession. This coupled with the complex nature of ethics matters in general, make it tempting to dismiss the entire concept as some critics do, as too nebulous. Overuse of words such as care, caring and relationship in the medical context, careless use of these words in general, and the many definitions of these words make it difficult to articulate the care perspective without a great deal of explanation, tempting some critics to call it "incoherent." It also makes it difficult to study, write about and (I assume) to teach didactically. This in part explains, the lengthy detail to which participants went to

ensure that I (and others) would grasp the significance of the process they were describing.

Hollis (1994) states that caring as an ethical concept must be endowed with tangible value. In some small measure the findings might be helpful in this respect. I believe the participants have provided a rich description of the defining characteristics that they associate with the care perspective in the MedMap. Throughout the interviews participants described and commented on the distinguishing characteristics of the care perspective: treating the patient as a person, understanding and respecting relationships and taking into account the context of the person's life. One participant used the term "care considerations" to describe these characteristics used by all. Careful analysis of the stories and commentaries shows that these considerations were prevalent throughout the participants' responses and are often interwoven.

I believe that the term "care considerations" and the related concepts, as derived from this study will provide further clarification of the care perspective in the MedMap and will perhaps "endow caring with a tangible value" as called for by Hollis.

Also of significance, participants provided in addition to their descriptions and commentaries, actual examples of how they viewed and used the care perspective. In this study, the use of the care perspective in medical practice and medical education is embodied in the cases

chosen, in the dialogue between the physician and patient, in the physician's musing on the issues and in the language used, all of which provide further elaboration on the care perspective in the MedMap from the practitioner's point of view. These stories or narratives, in turn, provide a richer, deeper understanding of this complex approach. Participants' use of case-stories to explain their understanding of the care perspective seems to bear out Noddings' belief that in the medical field, the care perspective can "perhaps better show through its use of small narratives, how people should meet and treat one another and thus it may be superior in performing an educative function" (1992, p. 17).

It is of note that the commentaries and stories of the physician-educators in this study reflected several points that were made in the literature. These included:

1. **The inadequacies of the justice perspective.** Some physician-ethicists in the scholarly literature discussed what they perceived to be inadequacies of the justice perspective which is the current medical ethics theory. Participants echoed the claims in the literature that the principles of the justice perspective do not adequately meet their needs and expressed dissatisfaction with the justice perspective. In short, I found participants reiterating what some scholars were saying - that current theory was not sufficient.

2. **A growing interest in the care perspective.** The findings resonated with the literature in that scholars and participants became interested in the care perspective gradually; they began with expressing dissatisfaction with the justice perspective, followed by a search for an ethical construct that they felt was in accord with medical practice. This led to an interest in the care perspective. Both scholars and participants noted that in medicine there are unique ethical situations that called for a distinctive and relevant approach to medical ethics. In general, participants believed an ethical decision in medical practice could not be made without addressing and adhering to the core values of the care perspective and indicated that they therefore have adopted, at least parts of, the care perspective in their medical practice and their own MedMap.

3. **The importance of people, relationships and context.** While these characteristics were briefly discussed by proponents of the care perspective in the medical ethics literature, participants have elaborated at much greater length and with much more specificity.

A few renowned medical scholars, such as Osler and Peabody, throughout this century placed human relationships at the center of ethical concerns and decision making. Proponents of the care perspective (Noddings, 1984; Gilligan, 1982; Levine, 1990; and

Carse, 1991) argue that the care perspective is an ethical theory that focuses on relationships as well as empathic responses to the context and life situations of others. Participants personalized these theoretical concepts. They repeatedly indicated that they had to re-educate themselves to treat people not diseases. They discussed at length medicine's need to see patients and physicians as participants in multiple relationships that influence the MedMap. They reported their ethical decision making now begins with understanding their patient, knowing who the significant person(s) are in his/her life and respecting the importance of these relationships in the MedMap. They also emphasized the need for physicians to learn about and understand the context and life circumstances of a patient. They liked the care perspective because they believed that it takes into account the complexity of human relationships and life circumstances influencing ethical decisions.

Participants also talked about what in the literature is called a "web" or a "network" of relationships. Participants indicated that the physician/patient relationship is at the center of the web of relationships which then radiates out to encompass many others. Participants viewed all these interconnecting relationships as significant in ethical behavior, thought, and decision making in

medical practice and ethics education. Several noted that a unique feature of the care perspective is this explicit recognition that patients do have significant relationships that bear on the MedMap. In this respect their responses echoed the literature, vis-a-vis the importance of caring human relationships in the care perspective and in the MedMap.

4. **The need for an ethical theory that is relevant to daily issues as well as extraordinary ones.** This point was made in the literature by one scholar who worried that there was too much emphasis in medical ethics on extraordinary ethical dilemmas and not enough on everyday events. It was also made by most participants who overwhelmingly agreed. Participants said that traditional ethics tended to focus on headline-grabbing medical cases. They stated that the care perspective recognizes that common everyday decisions as well as life and death decisions are part of medical ethics. Participants believed ethical decisions were based on details and complicating inter-woven meshes of persons with their conflicting desires, values, perceptions, goals, agendas and time pressures. Participants reported they used the care perspective because it recognizes the complexity of the values and needs of patients, health care providers and significant others, amidst the details and pressures of their lives, as valid influences on

the ethical decision making processes. Participants felt the care perspective encouraged them to take these influences into account when seeking ethical resolutions. They believed that the care perspective was useful in that it reflected the reality of their own MedMap. This was not an unusual or surprising finding but it was more fully developed in the findings than in the literature.

5. **Whether the care perspective is an ethical construct.** In the literature there is a great deal of interest in theoretical debates about what the care perspective is, what it represents, how it might be useful and where it fits in ethics. For example, is the care perspective an ethical construct? As stated earlier in the literature, both Levine and Carse maintain that the care perspective is an ethical construct and/or theory. They see it as organizing ethical thinking and decision making in a different way and providing another framework essential for examining ethical issues that influence patients and patient care. Opponents argue that the care perspective is not important or fundamental enough to rise to the level of ethical construct. Some suggest that it is little more than a communication skill.

Participants expressed less interest in theoretical matters than the literary scholars; they addressed a few of the theoretical concerns in the

literature but expressed little interest in others, and in general, expressed a pragmatic attitude regarding the care perspective. I derived from the responses that participants believe that the care perspective contains primary values intrinsic to medical practice and medical ethics, that it is an important concept in ethical decision making in the medical setting, that it is an ethical approach which furnishes them with the right tools to make ethical decisions with their patients and is an important concept to be taught in medical ethics education. Other than that, participants did not seem to be concerned, in general, with the theoretical debate.

Whether the care perspective is or is not an ethical construct or theory was and probably will be the subject of much future scholarly debate. The findings did not solve this issue but shed some light on it, perhaps opening it up for more general discussion.

6. **Whether it is compatible with the justice perspective.** Several participants responded to this theoretical concern in the literature. Some scholars have suggested that the care and the justice perspectives are, in fact, incompatible paradigms. Generally speaking, participants viewed the care perspective as complementary to traditional ethical theories, but again, weren't very interested in such debates.

Instead, they had "cut to the chase" and had made the decision that they liked the care perspective and thought it worked so they use it. They reported that regardless of what it was formally called they use the tenets of the care perspective in their ethical decision making, often along with the principles of the justice perspective. They admitted that they and other practitioners probably did not think deeply about ethical theories when making decisions due to time pressures, gut responses and the personal nature of most conflicts.

Participants appeared to be more open than scholars in including, mixing and using many different approaches to the MedMap. They did not feel that they were confined or bound to any one particular approach. They stated simply that they try to do the right thing at the right time for their patient.

7. **The care perspective as a natural fit in medical practice.** Levine and others who criticized present medical ethical theory as not meeting the needs of the medical practice and as omitting the care perspective, called for inclusion of the care perspective in medical ethics education stating that it was inherent in medical practice and a natural fit. The findings show that participants too consider this a natural fit and are presently using the care perspective. Participants seemed to have an almost intuitive

understanding of the care perspective. It made sense to them. Participants could articulate characteristics of the care perspective and were certain they used at least some of them in practice.

In general, the literature, seems restricted or confined to theoretical issues such as, what the care perspective is, if anything. The literature did not directly address the issue of whether physician-educators or practicing physicians were using the care perspective. The findings suggest that participants use the care perspective a great deal more than the literature would indicate, implying that perhaps theoreticians should study the care perspective's present use in the MedMap.

Participants also presented some practical issues that were thought provoking but not found in the literature. Virtually all participants expressed their concerns that the care perspective is often absent from the MedMap. In fact, participants stated their beliefs that the MedMap, without the care perspective, was flawed. Participants expressed concerns that without the care perspective, physicians and medical students may apply ethical principles in a mechanical fashion. In addition, participants expressed a different concern: that some might misunderstand the care perspective and invoke it incorrectly to justify inappropriate behavior. The

literature did not address types of practical problems such as these that the participants raised.

Participants observed again and again that as physicians they are the decision-makers along with patients, seeking the right decision for a particular person and purpose and in a given circumstance. For them, theories are not useful unless they have practical application and are easily understandable. Again the literature rarely mentioned this.

8. **Use of the care perspective could avert lawsuits.** The literature on medical practice suggests that when satisfactory relationships exist between physicians and patients, patients are much less likely to file lawsuits. In the ethics literature, some proponents have stated that they believe the use of the care perspective in the MedMap could reduce litigation (Kass, Levine). Several participants expressed similar beliefs that the likelihood of situations that lead to ethical impasses or even lawsuits is reduced through the care perspective. For example, Dr. I stated that, in her experience, patients sue doctors when they are angry with them; angry at how they are (mis)treated as human beings rather than angry with the competence of the medical intervention.

9. **The teaching of the care perspective.** The literature gave little information regarding the teaching of the care perspective in medical ethics education or in

medical education. Participants expressed concern that their own medical ethics training was not satisfactory or complete and they extended that concern toward current medical students whose training in ethics theory does not include the care perspective.

Most participants believed the care perspective ought to be taught in medical ethics classes and to be modeled in clinical training. Participants believed that values such as empathy, compassion, sensitivity to others, self care, focus on bonding relationships and nurturing, that are characteristics of the care perspective, need to be made visible, discussed, understood and used. Through medical ethics education, participants wanted students to develop their own understanding of the care perspective much more quickly than they had done. Participants strongly suggested that training students in the care perspective would enhance the professional satisfaction they acquired through their work and would lead to better patient care. They indicated that by teaching the care perspective and making it explicit in medical practice, young physicians would be given an ethical tool they can understand and use.

While advocating the teaching of the care perspective, participants spent only a small portion of their time discussing methodology, evaluation, and other educational

issues which would need to be addressed. Thus there are few detailed suggestions on how to incorporate the care perspective into medical ethics education in either the literature or the findings.

There are even fewer details on expanding the care perspective into the broad picture of medical education in the literature. Carse suggested that the care perspective could potentially be important in medical education as well as medical ethics education. Several of the participants, though relatively unfamiliar with the literature, expressed views that were congruent with this point. Again the views of the participants in the study went beyond echoing the literature. The literature merely hinted at potential linkages and connections, whereas some participants actually recommended formal connections and even collaboration with other health care professionals in teaching and evaluating the care perspective in medical ethics education and medical education.

Insights

The narratives in this study were for me a rich seedbed from which I was able to glean six important insights into the connections between medical practice, medical ethics, medical education and the care perspective. The findings persuaded me that some educators and practitioners as well as some scholars want to find a place

for the care perspective in medical ethics theory and in medical ethics education.

From the findings I gleaned the following insights. The first insight: the care perspective is used by some physician-educators in the MedMap rather routinely although often without receiving much explicit attention.

A second insight: the care perspective, so simple, so commonplace, so full of common sense, appears to be intuitive and/or inherent in medicine. The third insight: recognizing this humble commonplace concept seems revolutionary in one sense, that of returning to basics or to beginnings. (In another context, a scholar wrote about a "revolution in the geometric sense of returning to the beginning." I think that this applies here, too.) By including the care perspective explicitly in medical ethics theory and education, educators would be placing emphasis back on the human face of illness and suffering. The revolution would be completed by returning the emphasis in ethics to creating and maintaining caring relationships between doctors and patients.

A fourth insight: the care perspective is concerned with the presence or absence of common attitudes and behaviors surrounding ordinary experiences, applies to all people and thus seems to be universal in scope. The participants all seemed to be describing situations where they reconnected with simple truths, indispensable to medical practice and medical education. These truths, such

as, acknowledging and respecting a patient's personhood, and a patient's relationships with others are core characteristics of the care perspective. I was surprised that given (1) the universality of the care perspective, and (2) participants' description of the care perspective as essential to the MedMap and critical to patient care, participants had not been more assertive long before now about including this approach explicitly in medical ethics education.

A fifth insight: Participants expanded the notion of what constitutes ethical issues and matters. Participants familiar with the care perspective seemed to believe that the realm of ethics included many more issues than are included in traditional ethics (i.e., the justice perspective). For example, participants included the well-known transplant and life-support issues as ethical issues but also stated that they believe interaction, sensitivity, and receptivity issues, among others, belong in the ethical realm. More specifically, participants gave ethical status to "bedside manners." They carefully explained that bedside behaviors or actions are misnamed, being far more important than mere manners and suggesting that instead they have moral/ethical implications such as respect for individuals and for relationships. This insight made me wonder who decides what is an ethical issue. Who should decide what is included in medical ethics theory?

Will the care perspective lead to the "ethicalization" of much of medical practice? The blurring of lines is going on elsewhere in medicine. For example, issues which were once called social issues, such as violence, substance abuse and child abuse have now become the province of medicine or "medicalized." So, too, medical issues like treatments, drugs, diagnosis and patient care have become social issues. Along somewhat comparable lines, participants seemed to "ethicalize" many medical situations.

A sixth insight: I gleaned from the findings that some participants were calling for closer interaction and collaboration with other health care providers. This spurred two separate thoughts. First, collaboration would herald a unique departure from the discipline of medical education that has long been mainly insular and self-regulating. Secondly, given that these participants have accepted the care perspective, ideas of expansion (of the range of ethical issues) and inclusion (of non-physicians in the teaching of medical ethics) may not be surprising. The care perspective, with its emphasis on relationships, may be at work here already in that participants were acknowledging the need for and acceptance of collaboration in ethical areas to provide better patient care and better medical ethics education.

A seventh insight: the care perspective is used by some physician-educators in the MedMap as much to prevent

ethical dilemmas from arising, from getting out of control, and from reaching stalemates as to resolve problems. In addition, the use of the care perspective appears to have medical/legal implications. Several of the participants believed that physicians who use "the care considerations" (i.e., treating the patient as a person, respecting relationships, and understanding the context of the patient's life) are less likely to become embroiled in lawsuits. The findings suggested to me that there may be a new concept emerging - that of "preventive ethics." Howe (1993) and a few other ethicists have recently used this term, in a sense comparable to the term "preventive medicine." Perhaps the care perspective will find its home here.

From the findings, it was clear to me that physician-educators must be actively involved in defining the content of medical ethics theory. If medical ethics is left to non-physicians, huge discrepancies may arise between what is taught and what is practiced. This may lead to a private professional ethics being coined exclusively by physicians and a new isolationism. Theoreticians (especially philosopher ethicists who bring much knowledge, logic and analytical skills to the field) need to increase their own understanding of ethical decision making in the medical setting to counter a growing interest in a separate ethical approach to medicine.

Further Study

This was an exploratory study of a small group of highly trained, intelligent and thoughtful individuals. Although the sample may be unique, a group of physician-educators such as this has great influence on medical practice through the training of physicians. In general, these particular participants believed the care perspective is useful, important to medical ethics, and should be taught. These findings might spur further study of the care perspective in the MedMap and in medical ethics education. From these findings, it may be possible to determine the application, modeling, teaching, and evaluation of the care perspective in broader settings.

My findings contained only a few specific ideas on the subject of incorporating the care perspective into medical ethics education. Further study is needed in this area, such as exploring didactic and modeling approaches to the care perspective in the MedMap and also exploring ways to evaluate or measure the care perspective in medical ethics education.

Before that can be done, there is a need to further define and clarify the care perspective in the MedMap. The three "care considerations" so named by one participant but described by all - considering and treating the patient as a person, considering and respecting relationships and considering the context of the person's life, - may partially fulfill this need. Despite participants'

descriptions of characteristic features, I believe more scholarship needs to be done to define and describe the care perspective in medical ethics. A more precise definition, common terminology and common understandings are needed before instruction and evaluation of the care perspective in medical ethics education can go forward. My general sense is that future research will continue to be in this direction.

Another area of future study will be to find out how widespread the knowledge and use of the care perspective is among various groups. As noted in Chapter 4, it is unknown whether participants were representative of medical ethics educators at JCMS. Compared to the total faculty at JCMS, however, participants were younger; there were more women, more generalists and more ethnic minorities. Further studies might explore whether the number of years of clinical experience or race, gender, or age create differences in the familiarity with and use of the care perspective in medical practice and in medical ethics education. Is there a difference between physician-educators who are specialists and those who are generalists in the use and understanding of the care perspective? Along similar lines, it would be useful to know how widespread the knowledge and use is among medical ethicists. Are there differences between philosopher-ethicists and physician-ethicists? How widespread is the knowledge and use (1) among physician-educators who teach

medical ethics? and (2) among physician-educators who do not teach medical ethics? Is the care perspective only known among the academic elite or is it generally known and used?

A related area of study is whether use of the care perspective enables physicians to make better ethical decisions. Is their greater patient satisfaction? physician satisfaction? Are there fewer law suits? Can one use the care perspective to build a relationship with a patient or student who is behaving unethically at that point and change the dynamic from unethical behavior to ethical behavior? Other areas of study might include the impact, if any, that managed care will have on the use of the care perspective, the MedMap, and medical ethics educators.

The findings of this study raise many new questions including those mentioned and I believe that further study and scholarship on the care perspective in medical ethics education is merited.

REFERENCES

Annas, G. J. (1984). When suicide prevention becomes brutality: The case of Elizabeth Bouvia. Law and the Life Sciences, 4(2), 20-21, 46.

Annas, G. J. (1988). Not saints, but healers: The legal duties of health care professionals in the AIDS epidemic. Public Health and the Law, 78(7), 844-849.

Baier, A. (1987a). The need for more than justice. In M. Hanen & K. Nielsen (Eds.), Science, morality, and feminist theory. Canadian Journal of Philosophy, 41-56.

Baier, A. (1987b). Hume, the women's moral theorist? In E. F. Kittay & D. T. Meyers (Eds.), Women and moral theory (pp. 37-55). Totawa, NJ: Rowman and Littlefield Publishers.

Beauchamp, T. L., & Childress, J. F. (1989). Principles of biomedical ethics (3rd ed.). New York: Oxford University Press.

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley.

Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. Advances in Nursing Science, 8, 1-14.

Bogdan, R., & Taylor, S. J. (1975). Introduction to qualitative methods. New York: John Wiley.

Bulger, R. J. (1987). In search of the modern Hippocrates. Iowa City, IA: University of Iowa Press.

Carper, B. (1986). The ethics of caring. In B. Carper, Ethical issues in Nursing. Rockville, MD: Aspen Systems Corp.

Carse, A. (1991). The voice of care: Implications for bioethical education. The Journal of Medicine and Philosophy, 16, 5-28.

Chapman, C. R. (1979). On the definition and teaching of the medical ethic. New England Journal of Medicine, 301, 630-634.

Churchill, L. R. (989). Reviving a distinctive medical ethic. Hastings Center report, 19(3), 23-34.

Clouser, K. D. (1988). Teaching bioethics: Strategies, problems and resources. The Hastings Center: Institute of Society, Ethics, and the Life Sciences.

Condon, E. H. (1992). Nursing and the caring metaphor: Gender and political influence of the ethics of care. Nursing Outlook, 40(1), 14-19.

Cooper, M. C. (1991). Principle-oriented ethics and the ethic of care: A creative tension. Advances in Nursing Science, 14(2), 22-31.

Crabtree, B. F., & Miller, W. L. (1992). Doing qualitative research: Multiple strategies. Newbury Park, CA: Sage Publications.

Fox, R. C. (1990). Training in caring competence. In H. C. Hendrie & C. Lloyd (Eds.), Educating competent and humane physicians (pp. 199-216). Bloomington, IN: Indiana University Press.

Fry, S. (1989a). Toward a theory of nursing ethics. Advances in Nursing Science, 11(4), 9-22.

Fry, S. (1989b). The role of caring in a theory of nursing ethics. Hypatia, 4(32), 88-103.

Gaylin, W. (1976). Caring. New York: Alfred Knopf.

Gilligan, C. (1982). Psychological theory and women's development. Cambridge, MA: Harvard University Press.

Gilligan, C., Ward, J., & Taylor, J. (Eds.). (1988). Mapping the moral domain. Cambridge, MA: Harvard University Press.

Gillon, R. (1992). Caring, men and women, nurses and doctors, and health care ethics. Journal of Medical Ethics, 18, 171-172.

Glaser, B., & Strauss, A. L. (1967). The discovery of grounded theory. New York: Aldine.

Hendrie, H. C., & Lloyd, C. (1990). Educating competent and humane physicians. Bloomington, IN: Indiana University Press.

Hollis, R. S. (1994). Caring: A privilege and our responsibility. Obstetrics and Gynecology, 83(1), 1-4.

Howe, E. G. (1992). The care perspective and its application to clinical practice. Journal of Medical Ethics, 3(1), 3-7.

Howe, E. G. (1993). Preventive ethics and alleviating care providers' stress. Journal of Clinical Ethics, 4(4), 283-286.

Jonsen, A. R. (1990). In the new medicine & the old ethics. Cambridge, MA: Harvard University Press.

Kass, L. (1990). Practicing ethics: Where's the action. Hastings Center Report, 5-12.

Kittay, E. F., & Meyers, D. T. (Eds.). (1987). Women and moral theory. Totowa, NJ: Rowman and Littlefield.

Kuzel, A. J., & Like, R. C. (1991). Standards of trustworthiness for qualitative studies in primary care. In P. Norton, M. Stewart, F. Tudiver, M. Bass, & E. Dunn (Eds.), Primary care research: Traditional and innovative approaches (pp. 138-158). Newbury Park, CA: Sage Publications.

Lazare, A. (1987). Shame and humiliation in the medical encounter. Archives of Internal Medicine, 147, 1653-1658.

Lazare, A. (1992). Personal communication.

Levine, R. J. (1990). Medical ethics and personal doctors: Conflicts between what we teach and what we want. Journal of Clinical Ethics, 1(1), 23-29.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Monterey, CA: Sage Publications.

Marshall, C., & Rossman, G. B. (1989). Designing qualitative research. Newbury Park, CA: Sage Publications.

May, W. (1983). The physician's covenant: Images of the healer in medical ethics. Philadelphia: Westminster Press.

Mayeroff, M. (1971). On caring. New York: Harper and Row.

Miller, J. B., & Stiver, I. P. (1993). A relational approach to understanding women's lives and problems. Psychiatric Annals, 23(8), 424-431.

Moore-West, M., Regan-Smith, M., Dietrich, A., & Kollisch, D. O. (1990). Innovations in medical education. In H. C. Hendrie & C. Lloyd (Eds.), Educating competent and humane physicians (pp. 128-173). Bloomington, IN: Indiana University Press.

Nelson, H. L. (1992). Against caring. Journal of Clinical Ethics, 3(1), 8-15.

Noddings, N. (1984). Caring: A feminine approach to ethics and moral education. Berkeley, Los Angeles: University of California Press.

Noddings, N. (1992). In defense of caring. Journal of Clinical Ethics, 3(1), 15-18.

Osler, W. (1903). On the need of a radical reform in our methods of teaching medical students. Medical News, 82, 49-53.

Parker, R. S. (1990). Nurses' stories: The search for a relational ethic of care. Advances in Nursing Science, 13(1), 31-40.

Patton, M. Q. (1986). Qualitative evaluation and research methods (2nd ed.). Newbury Park, CA: Sage Publications.

Peabody, F. (1930). Doctor and patient: Papers on the relationship of the physician to men and institutions. New York: The Macmillan Company.

Pellegrino, E. (1993). Metamorphosis of medical ethics. Journal of the American Medical Association, 1159-1162.

Pellegrino, E., Siegler, M., & Singer, P. (1991). Future directions in clinical ethics. Journal of Clinical Ethics, 5-9.

Petersdorf, R. G., & Turner, K. (1992). Are we educating a medical professional who cares? American Journal of DC, 146, 1338-1341.

Puka, B. (1991). Interpretive experiments probing the case-justice debate in moral development. Human Development, 34(2), 61-80.

Sherwin, S. (1989). Feminist and medical ethics: Two different approaches to contextual ethics. Hypatia, 4(2), 57-71.

Spinsanti, S. (1992). Obtaining consent from the family: A horizon for clinical ethics. The Journal of Clinical Ethics, 1(2), 95-98.

Strauss, A. L. (1987). Qualitative analysis for social scientists. Cambridge, UK: Cambridge University Press.

Toulmin, S. (1981). The tyranny of principles. Hastings Center Report, 31-39.

Vezeau, T. (1992). Caring: From philosophical concerns to practice. The Journal of Clinical Ethics, 1, 18-26.

Watson, J. (1990). Caring knowledge and informed moral passion. Advances in Nursing Science, 13(1), 15-24.

Watson, J. (1979). Nursing: The philosophy and science of caring. Boston: Little, Brown.

Watson, J. (19xx). New dimensions in human caring theory. Nursing Science Quarterly, 881(4), 175-181.